

## CHAPTER 6: CRITERIA FOR HEALTH REFORM POLICIES

*Public-private partnerships are heralded by some commentators as something of a 'panacea' for the developing countries. The lessons of grant-in-aid in India suggest that such policies should be treated with more caution (Tooley, 2004:71).*

*Because first of all there will always be constraints on the fiscus and the needs of our population grow all the time. We will have to rely on private sector money and private sector expertise. But through a partnership we still ensure that the poorer populations get increased access to health care as the years go forward. And there is still a role for the private sector even as we get socialised health care. We will never have the resources to provide the kind of things we need for socialised health care. I am very optimistic (Pillay, 2005).*

### 6.1 Introduction

By categorising countries into more similar groups, lessons emerge as novel individual policies are assessed. These lessons provide insight and understanding into the different contexts of individual policies and identify those aspects that become a determinant for future policy directions. However, to categorise countries into similar groups requires an empirically informed process in which health care systems are evaluated in relation to the health, social and financial policies. This process is central to Chapter 6 as it sets out policy features by highlighting governance and accountability practices that framed HIV/Aids strategies and policy in order to provide a framework for best practices in public finance.

Evidence derived from the previous chapters showed that various external factors played a determining role in pinpointing the key issues and best practices that affected performance and service delivery outcomes. The key contributors were identified as the impact of ideologies on the architecture of governance and state interventions; the symbiotic relationship that exists between the economy, society, political philosophy and its impact on public finance: the economic impact of the political philosophies of the developed countries and its influence on policy trends in the developing countries: the role that public-private partnerships play as a mechanism to strengthen policy capacity and improve the government's ability to deliver quality services. The delivery of quality

services were tied to the relative size of the private sectors and how supply and demand functions were intertwined with the intervention strategies.

These factors formed the background for Chapter 6 in identifying key issues and trends within a 4E framework. Interviews provided a measuring tool of what happens in the task environment. The key issues derived from the framework provided a benchmark for the measurement of performance within the national environment. By benchmarking the international key performance indicators (KPIs), opportunities were created nationally allowing for alternative strategies to build on relative strengths, thereby reducing the effects of constraints and weaknesses within the internal environment. Improving functional activities directly ensued in lowering the costs of service delivery to achieve value creation in the long term resulting in new best practice standards. Chapter 6 concluded with a social cost-benefit analysis, in which the social costs and benefits of utilising PPPs in the HIV/Aids environment are highlighted and the benefits of future supply over and above what it would be in the absence of the intervention are brought to the fore.

## **6.2 International best practice framework**

A 4E framework (effectiveness, efficiency, economy and equity) presented those key performance indicators that are critical success factors in the PPP environment and shape health care interventions. The framework further identified key issues in the public health care sector and public finance as this determined the benefits and opportunities available in health care.

### **6.2.1 Effectiveness: goal attainment in service delivery**

The developed nations play a determining role in global policy-making and the design of the global architecture. They influenced and shaped ideas on development thinking and prescribed the approaches that developing countries took towards state intervention (nation-societies). The interventions were influenced by the market forces that set the tone for development. Constitutionalism formed the basis on which democracy and development initiatives were introduced. Transnational interaction became a determining factor in policy and development initiatives especially in the health care markets. At the core of the health care markets were the MDGs which became an instrument of sustainable development in which the governance structures were developed to reduce social and economic inequities. The governance structures provide a management

framework for the distribution of health systems which are central to the effectiveness of strategies and establish priorities of public expenditure based on the improvement of existing and new infrastructure.

The promotion of health care is seen as an active part of the global governance system. It utilises global PPP to achieve its aim through the service sector. Arrangements are managed through GATS. The growth of global markets in health care is manipulated through PPP. Development thinking and the utilisation of PPP are enforced through human rights and the enlargement of people's choices which are interwoven into the democratic structures of each country. PHC (developed parallel to PPP) with its emphasis on equity strengthens the argument that health is a human right. PPP forms the link between the state, society and economy. Participation occurs in a bottom-up approach, instead of the traditional top-down hierarchy (vertical and horizontal networks) and involved co-operation amongst government, civic and international organisations and market forces. In the evolvement of these market forces multinational and transnational corporations (private sector) are powerful stakeholders in the PPP environment and the provision of goods while NGOs became important stakeholders in health service provision, research, support services and policy advocacy.

An effective state and a stable political environment are vital for the provision of goods and services in health care and form an integral part of capacity-building and good governance structures. These structures enhance efficiency and effectiveness through systems that are based on a decentralised approach. The decentralised approach assists in human resource development and improves quality in life, task specification through performance and project management. Task specification and performance management are tied to timeframes and outcomes-based approaches that encourage social and health care systems to operate in synergy and provide value for money. The expected outcome in quality is associated with performance management (total quality expectations). The total quality expectations consist of both motivators and satisfiers. The intrinsic value (motivators) provides functional quality that is offered in accessibility, reliability, durability, timeliness, completeness, excellence, accuracy and compliance with legal standards. The extrinsic value (satisfiers) is perceived as the technical quality services offered through human resources (knowledge and ability) and physical resources (technology, facility, medicine and apparatus) (See Figure 4.2). Performance

contracting and competition in the private market are central issues that focus on cost reduction in health care through greater use of managerial techniques and an accountability culture. Goal attainment is achieved through good governance and the development of new accountability structures. Customer orientation in the provision of health care in public services underpins the arguments of performance contracting and competition.

The raising and spending of public resources in health care are influenced by political philosophies. It underpins the citizen-state relationship as it defines those who are accountable and how power is applied in managerial, contractual, communal and parliamentary accountability. The combination of these four forms of accountability impacts on trade-offs between PPP and the traditional public administrative system. Administrative reforms support political decisions and philosophies in their strategies for raising and spending of public finance.

### **6.2.2 Efficiency: outcomes in health care**

The utilisation of PPP modifies market efficiency and improves outcomes and strategic intent. Market efficiency is achieved through the forces of competition and globalisation underscoring efficiency and effectiveness in intergovernmental and intersectoral relationships. It is argued that fewer conflicts exist between the disciplines of the market thereby making the pursuit of contracting in the public sector the preferred option of purchasing assets and services through prescribed procurement processes.

Allocative efficiency in health care focuses on the distribution of resources through the budgeting process according to government priorities in order to achieve programme effectiveness. This is based on an increase on returns, the effects of individual actions and the type of goods or services (rival or non-rival). Allocative efficiency requires local rather than central decisions regarding tax expenditures and finance structures and fosters national prosperity through investment in physical and human capital in the long term and the short term). Greater private income and economic growth support the concept of allocative efficiency.

An increased importance has been placed on market accountability as this leads to market efficiency. Health care markets encouraged the implementation of user fees in

order to contribute to revenue and improve service quality and customer satisfaction (WTP). Performance standards and cost-benefit approach assisted in determining future opportunities to overcome weaknesses and build on relative strengths. The importance of performance and good governance in the health markets demanded that new accountability agendas had to be created to fill the gaps that developed in current health care structures.

### **6.2.3 Economy: reducing health care costs**

Minimising intervention costs in health care resulted in economy and value-creating strategies. These value-creating strategies determined the type of role the government played in partnership agreements, as well as the way it applied the value-creating strategies towards reaching its strategic intent.

In the formation of partnerships, the government was required to transform its role into an enabling, a facilitating and a regulatory function. The formation of partnerships moved government into an enabling role in which the state pursued equality of opportunity through mechanisms that modified the markets in a mixed economy. PPP is a fiscal planning tool at the macroeconomic level and is integrated in the budgeting process. The budgeting process provides the government with a mechanism that utilises the private sector/economy to provide goods and services through subsidies or loan agreements. The private sector assists the government with capital through investments. The relative high transaction costs involved in PPP determined that it is policy in most countries not to do straightforward PPP/PFI projects below a specified cost. The government identified health, education and housing as those sectors in which PPP work well.

Partnerships transformed the government into a facilitating and co-ordinating role in its production of social goods through the management of internal markets and managed competition (procurement processes through competitive tendering). It moved procurement in PPP from public sector comparator (PSC) to a more holistic approach in which more weight is given to the quality of competition, standardisation of PFI contracts, payment mechanisms and output specifications as well as the contracting out of public services to suppliers in health care. The value of the co-ordinating role that unions play in the design of PPP agreements must be taken into consideration. Appropriate legislation must be in place to deal with public sector transfers and benefits.

Partnerships compelled government to take on a more regulatory role through the application of coercive powers and primary legislation to provide security to long-term contracts. Security is given upon the basis of which services as a provider is regulated and bound up in terms of the concession agreement. The economic and social regulations encourage actors to undertake certain activities and enable them to make value choices.

#### **6.2.4 Equity: social justice**

Market-based approaches in a mixed economy transformed budgeting and allocation. Public expenditure management linked expenditure to measurable results and value-for-money approaches tied to horizontal or vertical equity in the budgeting process. Finding the optimal balance between socially acceptable distribution of income is a critical success factor in the development of social justice systems. However, it must be kept in mind that greater vertical equity cannot be at the expense of social justice.

#### **6.2.5 Implications of the 4E framework for the public sector and public finance**

Various implications for the public sector in the PPP environment must be considered when “best practices” are established in health care. The social model regulates health care inputs with a central focus on development, equity and empowerment. This is achieved through partnerships in which a heavily constrained state is able to share health care costs. Partnerships are at the core of relationships in the provision of health care and must offer affordability (economy) and efficiency, value for money, quality and accessibility (effectiveness). By transferring some risk increased security and equity needs. These outcomes require a heavily constrained state in which allocative and distribution policies determine how economic efficiency and social justice are applied, the borrowing/GDP ratios necessary to support its social needs are influenced by political philosophy, and infrastructure development is a critical element in sustainable development. The conditional welfare state is supported by public and private health insurance. The relative scale of public finance identifies the balance between social and economic spending which is crucial for wealth creation and the physical well-being of citizens. GDP indicates the relative size of the public/private sector. Health care is inflationary because it is supply-driven, high-tech and super profits are to be made

(rivalry). Private sector shows signs of strong growth through the successful utilisation of PPPs.

There are various technical implications for public finance that must be considered while evaluating the impacts of PPP has on public finance. An enabling state with heavily constrained public finance seeks additionality of finance through private and public investment driven through partnerships. This is encouraged through economic growth and efficiency and by increasing borrowing debt for efficiency purposes. Sustainable projects are identified and risks are managed in various stages of the PPP process (completion, bidding and development costs, return-on-investment (ROI), participant and operational failure, financing costs increase due to interest rate changes and technological impacts). Co-operative finance structures are intertwined in the budgeting process while borrowing debt for efficiency purposes through loans is influenced by external factors and risks (foreign exchange, syndication risk, political decisions, and interest rates). The internal factors and risks are influenced by the participants in the project, the way agreements are negotiated and the impact of proportional taxes on allocation policies. The internal processes such as the management of projects impact on completion time and costs involved, as well as oon technology, environment (labour and administration), and site issues (design and construction). The government contract/agreements and how it is negotiated are key success factors in the formation of PPP agreements as relationships and co-operative structures change in an enabling environment. The legislation, political ideologies, human resources and skill levels must support the initiatives. Proportional taxes are linked to decentralised structures to support budgetary processes and allocative efficiency.

### **6.3 Situational analysis**

Trends or patterns of behaviour influence the way in which business is conducted in the public and private sectors. The accelerated change demands the crucial responsibility to ensure the capacity for survival which can be done by adapting and by anticipating changes in ways that provide new opportunities for growth and development. The impact of changes on the remote environment (external) and task environment (internal) must therefore be understood and predicted. Through a situational analysis, environmental variables that are critical to survival are systematically identified (Pearce & Robertson, 2000:158-164; *cf.* Landsberg, 2002:41).

### **6.3.1 External environment (Remote environment)**

Key issues in the remote environment highlighted in Table 2.1, are used to assess the national health care environment. The PESTLE analysis (Table 6.1) assessed the remote environment and identified those factors that influence decision-making in health care and HIV/Aids intervention strategies.



**Table 6.1: PESTLE analysis for national case study**

<b>CASE STUDY 5</b>	
<b>The ideology: NEO-LIBERALISM (quasi-federal system)</b>	
<b>P</b>	<p>The Republic of South Africa is a constitutional democracy with a three-tier governmental system and an independent judiciary operating under a parliamentary system (bicameral). Unlike the Westminster-style parliamentary systems, the president is both the Head of the State and the Head of Government. The bicameralism is an integral part of the system of intergovernmental relations (Levy &amp; Tapscott, 2001). The Constitution of the Republic of South Africa 1996, as well as the White Paper on Reconstruction and Development of 1994 guides development in South Africa (ANC, 1994). The Constitution introduced the concept of a social welfare state in which government is expected to create conditions in which individuals can develop their social and physical well-being (Van der Walt, Van Niekerk, Doyle, Knipe &amp; Du Toit, 2002:7).</p> <p>The Constitutional framework provides for a decentralised approach which has both unitary and federal qualities and is run on a system of co-operative governance that was specifically formulated to suit the deeply divided plural societies. The Constitution of the Republic of South Africa, 1996 determines that public administration must be governed by democratic values and principles (Van der Waldt &amp; Du Toit, 1999:13; Coetzee et al., 2001). These principles include a development-orientated approach to service delivery by which government is able to respond to people's needs through the encouragement of grass-roots participation in policy-making (World Bank, 2001). Democracy is about social justice. Sufficient wealth and prosperity broadens the tax base and provide income to pay for the social welfare services to poorer communities without crippling the economy (Van der Walt et al., 2002:7). Health is identified in the Constitution of the Republic of South Africa, 1996 as a concurrent function. Concurrent areas of the national and provincial legislative competence thus dealt with these social and economic factors in the functional areas described under Schedule 4 and indicate those social and non-social functions that can be performed by both spheres of government in order to improve the quality of life of society through development initiatives. As the Intergovernmental Fiscal Review (1999) indicate, non-social services are important for promoting provincial economic development and poverty alleviation and include economic affairs such as trade, tourism and industry, public works, transport, local government, housing and agriculture. The National Health Act, 2004 (Act 61 of 2003) and the Draft Health Charter (Charter of the Public and Private Health Sectors) play crucial roles in aligning and supporting the development of organisational structures in the functions, "Health services" and "Municipal health services" in a system of co-operative governance as is specified in Section 41 of the Constitution of the Republic of South Africa, 1996.</p>

Government sees itself as an enabling state in which market-based strategies determine that a development-orientated approach facilitate and regulate economic growth and efficiency as a prerequisite for applying social justice through horizontal equity. Heavily constrained public finances support the high demands made on social security and health care services. The introduction of the White Paper on Transforming Public Service Delivery (1997) brought a new attitude amongst public servants regarding service delivery, namely *Batho Pele*, forward. The main focus is placed on improving service delivery outcomes by strengthening government policy capacity and administrative structures. This meant a shift away from the inward-looking rigid bureaucratic systems towards a more flexible, faster, and more responsive way of working, advancing the needs of the community through a more customer-focused approach. The changing needs and shift in service delivery outcomes brought new challenges and risks that increased the complexities associated with decision-making and responsibility. Vision linked to strategic impact became the pivotal point in decision-making and framed service delivery outcomes (Moorman, 2001:83). This systems-level approach became consistent with the conceptual rationale for the presence of a strategic impact that required the reaching of objectives and goals in set timeframes, creating-value services that are both transparent and accountable. PPP became one component of government's overall tools of implementing the development strategy for the provision of public services and infrastructure. This was done by linking PPPs to the budgeting process and integrating it as a part of the fiscal policy that increases growth, equity, employment and price stability and thereby reducing social spending. By taking a closer look at the health sector and the impact of PPP projects on service delivery outcomes, one is faced with additional project risks associated with the complexities of intergovernmental relations. Local economic development (LED) in local areas receives recognition from national and provincial governments, funding agencies, NGOs and CBOs. Ketchum (2001:7) believes that with limited resources and the added pressure placed on local governments to deliver services, partnerships have proved to be a responsible fiscal way. LED share the common notion of development from below and describes localised economic activity initiated by a local community. LED is an endorsement of the ANC government's ideological focus and strengthens its principle of community-based development.

The Republic of South Africa (see Case Study 5) has become a significant player in world politics and is an important player in the IMF, the World Bank and the UN organisations. Its foreign policy seeks to prevent conflict and promote peaceful resolution of disputes by promoting democratisation, disarmament and respect of human rights. The country plays an important role in the upliftment of Africa. Asia and the Indian subcontinent and Australasia have become priority areas in its foreign policy. They are part of the Indian Ocean Rim (IOR) which encompasses

	<p>the eastern African coastal countries, the Arabian Peninsula, Australia and the Indian subcontinent. The IOR for Regional Co-operation (IOR-ARC) is an important regional economic entity (Attorneys, 2005). Strong reliance is placed on the Global Fund for the fight against AIDS, TB and Malaria (GFATM) to provide funds. The Joint Public and Private Initiatives (JPPI) bring together funding. However, emphasis is placed on the supply of drugs rather than building capacity to sustain treatment and preventative programmes. Canada is the largest provider of development assistance to South Africa and has granted the country the benefit of its General Preferential Tariff.</p> <p>PEPFAR: The supply-chain management contract is under negotiation in the Eastern Cape. Issues of importance are the review of fixed dose combination and co-packaged products.</p>
<p><b>E</b> <b>c</b> <b>o</b> <b>n</b> <b>o</b> <b>m</b> <b>i</b> <b>c</b> <b>a</b> <b>I</b></p>	<p><b>Market outcomes and government interventions</b></p> <p>Neo-liberal policies involve market-driven policies on trade, investment, employment and government spending which influence market outcomes and undergrid development (structural economic reforms) with regard to labour, social spending and poverty levels (ABSA, 1999). South Africa has avoided SAPs prescribed by the World Bank and IMF. However, one should keep in mind that Gear is a structural adjustment programme that is just as rigorous as those the international finance institutions draw up (Bauer &amp; Taylor, 2005:340). The survival of governments depends increasingly on its external resources, exterior respectability and interior legitimacy. The South African free-market economy is the largest in sub-Saharan Africa. It is classified as a middle-income country by the World Bank. Its dual economic system and sophisticated industrial economy have developed alongside an underdeveloped informal economy. The stock exchange ranks amongst the 10 largest in the world. South Africa has a world class modern infrastructure supporting an efficient distribution of goods to major centres throughout the region and a sophisticated transport system and telecommunication facilities. The unemployment rate is 40%. The government intends to boost its public works programme to provide employment to the unemployed and unskilled. These programmes concentrate on 21 urban and rural nodes identified in terms of the Government Urban Renewal and Integrated and Sustainable Rural Development Programs (Attorneys, 2005). Economic growth has remained stable at 3% per year but has shown an improvement in 2004 to 4.8% in the second quarter of 2005. Agriculture forms less than 4.8% of the GDP.</p> <p>Big disparities exist between income groups which also have a significant impact on health care spending patterns and the relative size of public and private sectors. Privatisation and restructuring initiatives are main objectives in facilitating economic growth and promoting the</p>

development of disadvantaged and poor communities. Black empowerment and extended private ownership of government controlled-assets, the reduction of national borrowing as well as skills transfer and the promotion of fair competition are critical aspects that support governments main objectives (PPP represent these objectives) (Attorneys, 2005). South Africa is a founder member of the WTO and is amending its tariff structures in accordance with WTO rules and GATT. A trilateral trade pact exists between India, Brazil and South Africa. In January 2000, South Africa and the European Union concluded a trade, development and co-operation agreement. After passing the African Growth and Opportunities Act (AGOA) trade with the United States has grown as it ran trade surpluses with the United States. South Africa is a major beneficiary of AGOA. The United States exports higher-value goods to South Africa while the country exports auto components to the United States. AGOA benefits only limited countries as 75% of export under AGOA consists of unprocessed products such as petroleum and textile. South Africa's largest trade partners are the European Union, the United States and Japan. South Africa is the single largest investor in Africa.

#### **Government fiscal policies**

South Africa has a reputation for sound fiscal management. Both the fiscal and budgetary reforms have built a firm foundation through the development of a medium-term framework, strengthening revenue administration, adapting consistent planning into budgeting systems, stabilising the fiscal balances and investing in growth and development (Ministry of Finance, 2004). The macroeconomic strategy set out in the Growth, Employment and Redistribution (GEAR) strategy provided the basis for the objectives in 2001 which led towards an expansionary growth and pro-fiscal position that reduced the debt-GDP ratio, provided for a moderate inflation and healthy balance of payments and set the scene for economic growth and improved Standard and Poor's ratings. The PFMA, 1999 focuses on outputs and responsibilities that shape strategies and aim to improve public finance (Unit, 2004). Departmental heads of national and provincial departments are held accountable for their actions and must constantly evaluate their value-for-money choices. PPP entails targeted public spending according to outputs and predetermined standards, leveraging private sector finance and efficiencies and allocating risk to the parties which are best able to manage it (Unit, 2004). Project finance is generally used to finance PPP because they are mostly involved in some kind of infrastructural development project. These projects are closely integrated with Public Works Programs and BEE in PPP. The PPP Unit is seen as an enabler but is also a regulator as it has to control and steer the process. PPP are part of the budgeting process of government and firmly entrenched as part of the service delivery instruments (Treasury, 2005). Treasury Regulation 16, 2004 of the Public Finance Management Act (Acts 1 and 29 of 1999) laid the legal foundation for PPPs in the national and provincial sphere while the Municipal Finance Management Act, 2003 (Act 56 of 2003) and the Municipal Systems Act, 2000 (Act 32 of 2000) governs the process of PPPs in the local sphere through the Municipal Infrastructure

Investment Unit (MIIU). No PPP on municipal sphere is involved with health care or HIV/Aids interventions. The PPPs in the municipal sphere are involved in water, electricity, solid waste, fleet and other basic municipal services. Toolkits are being developed in areas such as tourism, health care and manufacturing. Government faces significant fiscal exposure through HIV/Aids interventions and welfare support. A means-tested disability grant of R740 per month is available to severely disabled people over 18 years of age. This includes people living with Aids. No clear policy on Aids-related disability grants exists. The number of people in need of disability grants has increased sharply since 2002. The children in need of childcare dependency grants have also increased. Costs associated with care dependency-grants will increase due to Aids. People who receive a disability grant and responds well on HAART are no longer eligible for a disability grant. Natrass (2004b) recommended that government introduces a new and lower income grant instead of taking away all financial support. Despite wide-ranging support for a basic income grant (BIG), government has been reluctant to endorse it. Finding alternative ways of channelling income into the hands of the poor and unemployed is based on PWP. Low-wage PWPs that target the poor through government-funded programmes have the potential to alleviate poverty and the additional benefit of creating assets and infrastructure. A major disadvantage is that a substantial proportion of resources is absorbed through administrative costs. BIG has the added advantage of reaching the poor that are too ill to work. Other options available to government to drive down costs of Aids treatment programmes are through an aggressive approach to drug pricing; support for domestic production of generic antiretroviral medication, namely i.e. Aspen.

#### **Economic systems and supporting economic policies**

The BEE is articulated in the Strategy for Broad-based Black Economic Empowerment Act, 2003 (Act 52 of 2003) (BBBEE Strategy) that facilitates broad-based BEE and provides a code of good practice to be applied in government and public entities when entering in partnership agreements. The BEE is woven into all the charters, such as the Finance and the Health Charter. PPPs are seen as a way to promote black empowerment within the South African economy. PPP supports and is good for social development initiatives. Procurement encourages fair and open competition within a mixed economy.

#### **Implications for the public sector and public finance**

Government's economic policy, Gear, is premised on investment becoming the driving force for growth. Hope was centred on investors responding to falling budget deficits and falling inflation. Government policy focus shifted to greater capital and skills intensity to provide more sustainable growth in the medium and short term. Skill shortages and the brain drain impacted negatively on growth. Aids added to skills-shortages and the brain drain. Its economy is much more capital-intensive than other economies in sub-Saharan Africa. Lessons learnt from

other countries with high HIV prevalence may not apply to South Africa (ABSA, 1999; *cf.* Arndt & Lewis, 2000:856). The macroeconomic impact of HIV/Aids on the South African economy was found to be substantial as it impacted on the GDP, lowering the population and per capita GDP by 8% (Arndt and Lewis, 2000:856). The macroeconomic impact will be felt through an increased pressure on public spending in health and social services.

Nattrass (2004b:87) states that unemployment and Aids are major challenges faced by the economy and social security system. Significant income disparities between incomes exist in provinces. The Eastern Cape and Limpopo are the poorest provinces (Guthrie & Hickey, 2004). Guthrie and Hickey (2004:102) state that there is a strong relationship between poverty and ill health and poverty-related illnesses. Even if modifications of high-risk behaviour change are implemented and begin to reduce the number of Aids deaths in the next five year, the full effect will still lag by a decade. Unemployed have neither access to earned income or life-prolonged medication. Aids impacts more on the unemployed and unskilled labour category. This affects mostly the youth. The economic impact of Aids is much higher than the growth rate of GDP or the effect of increased mortality on existing land as it destroys human capital and family structures (Bell, Devarajan & Gersbach, 2003). As the prevalence of the disease increases (due to the effects of absenteeism and morbidity), more progressive collapse of human capital and productivity will occur. Transmission of knowledge from parents to children is affected which will influence growth and education within three generations. The unemployment rate for unskilled labour increases as a result of the epidemic. Aids tend to affect young adults, is slow moving (illness has a gradual onset with declining labour productivity and increased health costs) and infection differs by skills class. The unskilled labourer is more vulnerable to the impact of Aids. Household expenditure is greatly influenced by the increase in health spending. Saving rates are affected creating a spending shift and an increased demand on governmental social spending. The epidemic has moved from a health issue to a development issue with social, political and economic dimensions (Arndt & Lewis, 2000:857). Poverty and Growth Programmes (PGP) builds on the capacity of middle-income countries and designs and implements effective poverty-reduction strategies. Developing countries are required to formulate poverty reduction strategy papers (PRSP) representing the macroeconomic, structural and social policies that achieve economic growth and poverty reduction. The PRSP describes government's commitment to poverty reduction in a participatory approach. These programmes must provide a three-year macroeconomic framework together with a policy matrix that includes the main elements of the poverty reduction strategy (Laterveer, Niessen & Yazbeck, 2003:138-145). Any strategy of poverty reduction must begin with an interim poverty-reduction strategy and include an assessment of the health and disability of the environment, age and size of families,

	<p>education levels and gender. Vertical equity implies that more resources are spent on the poor.</p> <p><b>Other scenarios:</b> Due to increased government spending on health one sees reduced spending on education. This reduces skills accumulation and changes labour force growth rates. Arndt and Lewis (2000:857) advise government to focus on policies that slow the spread of Aids and the demographic trajectory of the pandemic as well as emphasise the need to investigate the interactions between the pandemic and alternative growth and development strategies.</p>
<p><b>S</b> <b>o</b> <b>c</b> <b>i</b> <b>a</b> <b>I</b></p>	<p>Government takes a developmental approach to social and health reforms. The Constitution of the Republic of South Africa, 1996 confers rights on various social services and benefits which include housing, health care, social security and education. Provision is made for budgetary constraints in which it is seen as the responsibility of the state to make reasonable provision to expand access to the services or benefits (ABSA, 1999). Expanding access to services and benefits intends to advance social development by steadily reinforcing the social wage. This includes improving benefits such as nutritional needs, education and improving the well-being of poor households. Redistribution of wealth is a key tool that supports interventions enabling markets and strengthening them to work better in order to fund social development programmes that improve allocative and distributive strategies. The main challenge lies in resolving poverty and Aids simultaneously. This means it requires new ways of allocating funding from national to provincial spheres aligning it with the growth strategies and spending and taxation decisions. According to Natrass (2004b:87) this is done through direct interventions (income support and public works) and through policy measures that support labour intensive activities and growth in order to maximise employment outcomes. Social services continue to absorb nearly 60% of the government's non-interest expenditure. This expenditure is necessary to lay the foundation for growth in human capital and direct support to the poor (Treasury, 2004). The government aims to reduce the dependence on social grants, deepen the capacity of communities to meet their basic needs through normal participation in the economy. There is an increased focus on housing delivery and improved infrastructure to reduce the effects on health.</p> <p>Improving the health and well-being the government is working towards a social health care plan for all. Partnerships, especially PPPs and PPIs, have become dominant forces in public sector reform (Wettenhall, 2003:77). However, the government is faced by an uneven distribution (inequities) of health care and ownership of health establishments, poor accessibility to services, provision of necessary human resources and infrastructure to support health care structures are core issues to be solved in health care reforms. The National Health Act, 2004 (No 61 of</p>

2003) and the Draft Health Charter support this process of transformation towards a national health system (NHS). Amendments are recommended and accepted in the Budget, 2005 to the way medical aid contributions are taxed with the aim of lowering costs of medical aid and making medical aid accessible to poorer families. The development of a “basic package of care” that reflects the minimum standard of health services will assist in determining the public-private mix and balancing this ratio. Health care reform and privatisation has had a strong negative net effect on the public sector. Rapid expansion of private hospitals has undermined the public provision by draining large numbers of skilled staff and paying patients out of the public health system (Moorman, 2001:83; *cf.* Sanders & Meeus, 2002:4).

The White Paper on the Transformation of the Health System in South Africa (1997) initiated and guided this process of transformation. It stated that the activities of the public and private sectors must be integrated in such a way that it makes use of the available health care resources, and as such promote equity in service provision. All health care activities are aligned within the National Health Act, 2004 and the Public Service Regulations (2001) which together formed a comprehensive health care program. The implementation of a Primary Health Care Plan changed the focus of the health care systems from a medical problem towards a social model that encompasses the needs of the society it serves. Treatment moved away from expensive curative care to palliative care with an increased focus on preventative measures. PPP in health care offered the option to tap into the concentration of resources to the benefit of everyone (Moorman, 2001). The public sector saw PPPs as a mechanism to improve efficiency, customer service and revenue. The key prerequisite is centred on reduced cost through collaboration and closer interaction with the private sector which brings new management styles and facilitates new skills especially in finance. PPPs are long-term concessions with private sector to provide services or infrastructure on behalf of government and must provide value for money, affordability and transfer risk (Pillay, 2005) The health sector is currently engaged in substantial investments into the procurement of health care infrastructure and health care services through PPP projects, though there is substantial resistance against PPP in DoH. HIV/Aids is not specifically dealt with through PPPs. There is only one PPP in the Eastern Cape, called the Pharmaceutical Supply Chain Management PPP which is in its final stage of procurement and involves the management of the supply of pharmaceuticals for people (Pillay, 2005). This project is part of the PEPFAR (SCMC) funded by Global Health initiatives. It became evident that human resource practices within the health sector are closely linked to organisational strategies and goals. The success of the transformations within the health sector in each of the functional domains depended on both the line and responsibility manager’s ability to combine the administrative and management work areas together with effective human resource practices and their ability to utilise resources. The intergovernmental relations are tied into the contract



negotiations and role contracts in an effort to define the nature of intergovernmental relations. This is critical to the success of the PPP arrangements in the health sector (McCoy, Buch & Palmer, 2000:6). The difficulties associated with the construction of partnerships are nowhere as evident as in the delivery of the Primary Health Care System (PHCS). The responsibility for delivering a comprehensive PHCS can never belong to one level of the health system but requires a vertically integrated, tiered health care system where different levels of management and administration work together in a complementary way (McCoy et al., 2000:1).

Response to HIV/Aids was limited before 1994 and focused mostly on condom provision. Activity in Aids policy increased from 1999 to 2001. Much of the activities in the developing countries stemmed from the decision made by the South African Government to amend its Medicines and Related Substance Act of 1965 with a new provision referred to as Article 15(C) (Siplon, 2002:120).

1997: A Review of HIV/Aids Strategy and programmes

1998: The Partnership Against Aids. It also saw the establishment of the national Interdepartmental Committee on HIV/Aids (IDC) which was responsible to coordinate and support the HIV/Aids response.

The HIV/Aids and TB Unit was established in 2000 within the DOH. It also established a Donor Coordination Forum in which bilateral and multilateral donors were represented. Their activities were integrated into the national strategies and a national integrated plan (NIP). The Chief Directorate HIV/Aids and TB developed policy to support research and surveillance and administer and drive national programs. The Directorate is also responsible for managing the conditional grants to provinces and ARV treatment funds, NGO funds through an NGO Funding Unit (loveLife and LifeLine) and allocations for SANAC. Setting up NIP programmes entailed new management structures, employing co-ordinators in provinces, developing financial transfer and monitoring systems, formulating programme standards.

In June 2000, DOH launched the HIV/Aids/STI Strategic Plan for South Africa, 2000-2005 and the TB Medium Term Development Plan guiding DOH in setting objectives to improve multisectoral participation. The needs are further met in the Strategic Priorities for the National Health System, 2004-2009. The overall goals were structured according to four distinct components:

- Prevention: Communication through information improved awareness (Low-Beer & Stoneburner, 2004:5). Soul City has had considerable impact around HIV/Aids issues in South Africa. The Soul City model utilised the mass media vehicle through educational and health promotion aimed at 8 to12-year-olds (IHDC, 2005).
- Treatment

- Human rights
- Monitoring and research. The National Integrated Plan (NIP) is an inter-sectoral national government plan for responding to HIV/Aids. Three programs are jointly delivered by health (Prevention, treatment and care programmes are delivered by DOH), education (life skills, voluntary counselling and testing (VCT) implemented by DoE) and the welfare sectors (community and home-based care and support implemented by DSD).

**The main funding framework for HIV/Aids is organised into three streams:**

- Nationally financed and implemented programmes. These programs are funded primarily through the budget of the Chief Directorate: HIV/Aids and TB Unit in national DOH and are directed through conditional grants. Conditional grants are given to provinces for specific interventions and are the largest form of funding.
- The Provincial grants are increasing at a faster rate than the HIV/Aids conditional grants administered by DSD and DoE.
- The Provincial interventions are funded through the equitable share grant. These grants are intended to strengthen health care services (Guthrie & Hickey, 2004).

2000: the South African National Aids Council (SANAC) was established. It was restructured in 2003. The formal partnership between Government and the South African Aids Vaccine Initiative was established.

2001: Additional funding was secured through the “Enhanced Response to HIV/Aids and TB in the Health Sector”. The development of an Integrated Plan for Children and Youth Infected and Affected by HIV/Aids was developed. More emphasis was placed on co-ordinated care to deal with community home-based care, counselling and prevention.

2002: A revision of the “Enhanced response” allowed for further mobilisation of funds over a three-year period. IDCs were established in all the provinces. Partnerships with major sectors were strengthened. These included partnerships with pharmaceutical companies, traditional leaders, and high-risk areas such as shebeens, bars and taverns. The Diflucan Partnership Programme whereby Pfizer provided Fluconazole free of charge was extended indefinitely. Awareness campaigns focused on commuters, drivers, taxis and buses. During 2001, donor funds increased to a peak after which it gradually decreased (Guthrie & Hickey, 2004). However, it was found that it is difficult to provide an accurate figure of the amounts donors invest into HIV/Aids in South Africa as donor revenues are not included in the national budgets and expenditures are not synchronised with national spending patterns. South Africa provided a R20-million payment to the Global Fund.

2003: A mid-term review of the Strategic Plan was conducted and focused on government’s response. HIV/Aids and life skills were introduced

into education systems. A number of government departments integrated HIV/Aids programmes into their line functions.

**Local spheres: service delivery and budgeting for HIV/Aids**

DOH is the main authority to determine how the total conditional grant is divided between the nine provinces. Business plans are key factors in determining the amounts needed for effective interventions. In 2003 DORA relocated additional funds to provinces that were able to spend their income. DOH costs the components of interventions to be financed and submits its requests to National Treasury who elects to fund some components of the conditional grants fully or partially. The Directorate Financing and Economics in DOH is responsible for the costing of the expenditures. A new tool for sending money to the provinces for HIV/Aids was introduced in the 2002/2003 budget by drawing from the equitable share pool. For provinces, conditional grants funds are thus ringfenced for particular purposes defined by the national departments while the equitable share funds allow provinces the freedom to allocate the money where they deem necessary (Guthrie & Hickey, 2004). It is very difficult to track equitable shares as they are allocated via the provincial budget process. Details of expenditure are presented in parliamentary hearings and are reported in the Auditor-Generals report two years later. Ringfencing conditional grants caused bureaucratic hurdles and delays in spending and transferring funds. The bulk of public health expenditure is found in provincial budgets (98%) because provinces are responsible for service delivery and implementation. Provinces are reliant on the national government for their revenue and are largely responsible for service delivery. HIV/Aids requires focused budgetary allocations for specific programs and must provide indirect support to provincial departments to mitigate the impact of HIV/Aids and encourage a developmental response (Guthrie & Hickey, 2004). Allocations in health have shown a gradual increase in spending. Consolidated national and provincial health expenditure has grown with an average of 3.6% per year from 2000/01 to 2005/06. Expenditure as a share of the total budget and GDP: OAU Special Summit on Aids in Abuja in 2001 pledged 15% of national budgets to be allocated to health.

**NGO sector**

The government relies on NGOs for the implementation of HIV/Aids interventions at grass roots; for care prevention and support. Of the HIV/Aids and TB Unit's budget 7.5% was spent on NGOs and CBOs and an additional 4.8% was allocated to loveLife and LifeLine. CBOs identified the importance of "community development facilitators" in building relationships between the clinics, hospitals (medical professions) and local communities (patients). Service delivery within clinics depended on the administrative skills and management capacity of nursing sisters. Rural or urban clinic's quality of service depended on administrative skills and not on policy issues. Partnerships in health and social care with NGO and CBO were financed through conditional grants from provincial governments which are the implementers of service delivery.

	<p>The funding for services in NGOs and CBOs is tied to a strict regulatory system which is questioned by these organisations as the government seems ineffective in the management of data. More transparency of data will benefit all parties involved as they can measure performance and outcomes of services provided. It will offer them great benefits if they can improve on service delivery. The role of government in this partnership must be renegotiated.</p>
<p><b>T</b> <b>e</b> <b>c</b> <b>h</b> <b>n</b> <b>o</b></p>	<p>Problems with data and statements of expenditure were emphasised by:</p> <ul style="list-style-type: none"> <li>○ Government works on a cash accounting and not accrual system. Expenditure is recorded only when a payment is made.</li> <li>○ Provinces correct errors in books at the end of the financial year.</li> <li>○ No information on roll-overs of funds. Adjusted estimates are published in October and November and include information on funds rolled over in previous budget.</li> </ul> <p>Challenges faced by budgeting systems and health care delivery are based within human resources as a shortage of skills impact on systems and affects the implementation of programmes and interventions. An information system is developed by SITA. Data sources will include patient information systems, National Health Laboratory Services DISA, and district health information systems, BAS, impact research and evaluation research. Patient data will be stored in Master Patient Index and program information will be kept on M&amp;E data base. Data management protocols are necessary to control decentralised service delivery.</p>
<p><b>L</b> <b>e</b> <b>g</b> <b>i</b> <b>s</b> <b>I</b> <b>a</b> <b>t</b> <b>i</b> <b>v</b></p>	<p>The Health Act, 2004 shapes the future of the South African health system. The Health Act reaffirms the goals the 1997 White Paper for Transformation of the Health System in South Africa identified. Decentralised health care between the private and public sector professionals and providers are emphasised. Since 2001, numerous new judgments were passed from the Constitutional court that had a significant influence on HIV/Aids (Barrett-Grant, Fine et al. 2003:v, 93). These new judgments were in accordance with the international law and the United Nations Resolution, No. 1995/44, passed by the Commission on Human Rights calling for states to ensure that practices, policies and laws respect human rights standards. South Africa follows an integrationist approach in which informed consent and confidentially providing for dignity through antidiscriminatory treatment are the main objectives (Panda et al. 2002:167). Three judgments supported their action in supporting the guidelines set out in the International Law:</p> <ul style="list-style-type: none"> <li>○ <i>Grootboom</i>: The Constitutional Court stated that government must have clear plans to realise the socioeconomic rights. Plans must be reasonable and must meet the needs of the most vulnerable and at risk. Improving the quality of care was enforced through a Patients</li> </ul>

<p>e</p>	<p>Rights Charter launched in 1999 and in 2001 a National Policy on Quality was brought forward to co-ordinate provincial policies with a PHCS. Through an audit of the hospital infrastructure in 1996, it was found that one third of hospitals needed upgrading. The revitalisation of hospital infrastructure started of with strategic position statements that were converted into the Integrated Health Planning Framework (IHPF). This provided a planning tool to determine the shape and size of the health system. PPPs are seen as a method to invest in infrastructure and health care provision (Barrett-Grant et al., 2003:iii, 77).</p> <ul style="list-style-type: none"><li>○ <i>TAC and the Ministry of Health</i>: Dispute over extent of government's responsibility in prevention programmes using Nevirapine (Barrett-Grant et al., 2003:iii).</li><li>○ <i>The Jordan and Others v S and Others</i>: Criminalisation of prostitution was a violation of the constitutional right to equality and discriminated unfairly against women. (Barrett-Grant et al., 2003:iv).</li></ul> <p>The right to health forms the core issue on which all decision-making is based in international and national law. South Africa amended its Medicines and Related Substance Act of 1965 and replaced it with the Medicines and Related Substance Act of 2002. The WTO rules, (TRIPS), revolved around the application of the South African law. The US was demanding a TRIPS-plus; a level of accomplishment higher than the standard set by the WTO. The revision of Guideline 6 of the <i>International Guidelines on HIV/Aids</i> and Human Rights, 2002 recommended that governments have a duty to ensure that all people have access to health services essential for treatment of HIV/Aids. People have a right to access to “antiretroviral and safe and effective medicines” (Barrett-Grant et al., 2003:v,106) This ruling has a significant impact on budgeting decisions of government. Although international laws are recommendations they are important aspects in national legislation and jurisprudence. The private sector has specific regulations and compulsory registration of health care institutions and agencies is required. Specific legislation for HIV/Aids has been adopted in the work environment.</p> <p>The PPP Unit has been set up to regulate and oversee the regulatory framework in terms of national and provincial government institutions in how they established and enter into PPP agreements. The central legislation that governs PPP is set out in Treasury Regulation 16 issued to the PFMA, 1999. Each national and provincial department established its own PPP directive that is responsible to co-ordinate with the PPP unit and formulate projects that comply with the departmental strategies effectively are determined by the MTBPS and MTFPF. Local government and PPP agreements are governed through the Municipal Systems Act, 2000 and the MFMA, 2003. The municipalities are not subject to the</p>
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	PFMA or Treasury Regulation 16.
E n v i r o n m e n t a l	<p>Southern Africa is a land of enormous contradictions. It leads the continent as being the wealthiest per capita, most urbanised population, the greatest industrial base and the leading agricultural output. It has an abundance of natural resources and mineral deposits, natural gas, petroleum, boasts of vast transportation networks and communication networks. It has the highest HIV/Aids infection rates in Africa and is home to the world's fifteen poorest countries. South Africa, Namibia and Botswana are the strongest countries in this region. South Africa's economic development, its leadership and its hegemony all combine to give it a leading profile in the region. South Africa is a founder member of NEPAD and the African Union (AU). Through NEPAD health care commitments are met through sustainable development, sectoral priorities such as improved infrastructure and the mobilisation of resources in Africa. Its main goal is to eradicate poverty by meeting the MDG. NEPAD recognizes the interconnectedness between health and development, but does not recognise health as a basic human right or as an outcome of equitable development. HIV/Aids is inadequately dealt with as the country is unable to provide the most basic health needs. It encourages other countries to give higher priority to health in their budgets and increase health spending (Sanders &amp; Meeus, 2002:1-2; Attorneys, 2005).</p> <p>The World Bank initiated partnerships between public-private health sectors as the way forward as it is believed that the private sector is able to provide better technical efficiency. South Africa is one of the six countries that form part of the global HIV/Aids epicentre for the epidemic in the southern Africa region. The health care system is reeling under the impact of the epidemic (Bauer &amp; Taylor, 2005:248). South Africa experienced impoverishment and disenfranchisement, rapid urbanisation, labour migration, widespread population movements and displacements and social disruption. The virus is transmitted almost exclusively through heterosexual intercourse and a higher level of sex outside marriage which resulted in high level of STDs. These variables are grounded in individual behaviour and cultural norms. NGOs such as the TAC took the lead in challenging multinational pharmaceutical companies in South Africa to produce ARV drugs that sought to prevent the production of cheaper and affordable drugs. They have also forced government to supply ART to those in need of it. The migrant labour system involves internal migration of men from rural areas to mines and other places of employment. Influx controls were lifted which led to huge numbers of people from rural areas seeking better opportunities in urban areas. The migrant labour system contributes to a vicious cycle of poverty and facilitates the spread of HIV/Aids (Bauer &amp; Taylor, 2005:292). The SADEC Draft Protocol on Free Movement of persons in southern Africa contains the most radical and visionary model of future regional migration regime in southern Africa. Legal contract migration to mines and farms in South Africa were drawn from Botswana, Mozambique, Swaziland and Lesotho (Crush, 2003). The majority of</p>

undocumented migration comes from Malawi, Zimbabwe, Mozambique and Lesotho. An increase in undocumented migration has taken place from the rest of Africa, Europe, North America, Asia and the Indian subcontinent. Since 1990, South Africa has become a new destination for refugees from the rest of Africa (Crush, 2003) . The Mozambicans form 25% of the mining labour force.

**Southern Africa region:**

There are three principal organisations that represent different levels of economic integration in the southern Africa region: the Southern African Customs Union (SACU), the Common Market for Eastern and Southern Africa (COMESA) and the Southern African Development Community (SADC). South Africa has the most sophisticated manufacturing in sub-Saharan Africa (SSA), the best infrastructure, a highly developed mining industry and advanced agricultural sector. Its GDP is four times that of the other thirteen SADC countries combined. The SADC's principal function is an economic body but it is also involved in security issues in the region. It plays a pivotal role in the developmental of Africa.

The AU is established to foster continental unity and development. The launching of the Economic, Social and Cultural Council of African Union (ECOSOCC) is devoted to building partnerships between government and all segments of society. The organising principle of ECOSOCC is one of civil society (National NGO and CBO networks). NEPAD is the result of two competing visions for Africa: Millennium Africa Plan (MAP) articulated by South Africa and the Omega Plan advocated by Senegalese President A. Wade. MAP and NEPAD promote the African Renaissance (Venter & Neuland, 2005:7). NEPAD is intended to force international partnerships with the global north and on the continent. NEPAD rejects withdrawal from the world system and seeks greater integration into the global economy, embracing neo-liberal paradigms. It relies completely for its funding on donor organisations (Venter & Neuland, 2005:234). NEPADs African Peer Review Mechanism (APRM) materialised in 2003 (Bauer & Taylor, 2005:339). Participation in APRM is voluntary. South Africa is currently participating in the APR process.

Source: Adapted from ANC (1994); ABSA (1999); Nel (1999); Van der Walt and Du Toit (1999:13); Arnt and Lewis (2000:856-857); McCoy, Buch, Palmer (2000:1-6); Coetzee, Graaff, Hendricks, Wood (2001); Ketchem (2001:7); Moorman (2001:83); Levy and Tapscott (2001); Ketchum (2001); Landsberg (2002); Sanders and Meeus (2002:1-4); Siplon (2002:120); Panda, Chatterjee, Abdul-Quader (2002:167); Van der Walt, Van Niekerk, Doyle, Knipe, Du Toit (2002:7); Barret-Grant, Fine, Heywood, Strode (2003:iii-v, 77,

93, 106); Bell, Devrajan, Gersbach (2003); Crush (2003); Laterveer, Niessen, Yazbeck (2003:138-145); Wettenhall (2003:77); Guthrie and Hickey (2004:102); Low-Beer and Stoneburner (2004:5); Ministry of Finance (2004); Natrass (2004b:87-108); Unit (2004; Attorneys (2005); Bauer and Taylor (2005:248, 292, 339-340); IHDC (2005); Pillay (2005), Venter and Neuland (2005:7, 234).



Distilling the key issues from Table 6.1 offered insight into those factors in the remote external environment that influenced health care reforms and impacted on the strategies for HIV/Aids. Political ideologies and values are directly relevant to the actual practices that influence and shape political, economical and social policy-making strategies and the interventions selected. Likewise, politics and administration are inseparably linked to the outcomes of service delivery and the type of funding structures government utilises to support its intervention strategies towards health care reform as effectively, economically, equitably and efficiently as possible.

HIV/Aids proves to have a major impact on the government budget and its revenue structures. Balancing the economic efficiency and social justice determines how effective the state is in providing services contributing for the well-being of its citizens. Health and well-being improves productivity which becomes the key element in growth (economic efficiency) and which is central to welfare economics. A discussion follows in which the key issues that have the greatest impact on decision-making in the policy environment for Case Study 5 are highlighted:

#### **6.3.1.1 Political factors**

The British Westminster model with its doctrine of ministerial responsibility was firmly entrenched in South Africa by 1910. Policies adopted by each government since 1910 shaped the South African society and gave the background to the negotiations preceding the Interim Constitution of the Republic of South Africa, 1993. In a government of national unity, westernised norms and standards were replaced with policies that focused on the majority, indigenous and underdeveloped. The Constitution of the Republic of South Africa, 1996 introduced the concept of a social welfare state. The principles included a development-orientated approach to service delivery through grass-roots participation in the policy-making process. A system of co-operative government provided for a decentralised approach set out in section 40 which provided for a national, provincial and local sphere of government that is distinctive, interdependent and interrelated. The principles of intergovernmental relations are specified in section 41 of the Constitution. Health is identified as a concurrent function under Schedule 4A and indicates that the social and non-social functions can be performed in national and provincial spheres of government to improve the quality of life. The regulatory framework for PPP is based on section 217 (1) of the Constitution of the

Republic of South Africa, 1996 which emphasises the role of the accounting authority in all three spheres of government or any other institution identified within the national legislation and their responsibility. The regulatory framework emphasises effective and efficient use of fiscal resources in the public interest as well as the process of procurement which must be fair, equitable, transparent, competitive and cost-effective.

The main focus of state intervention is based on strengthening policy capacity and administrative structures to improve service delivery. The government is seen as an enabler through market-based strategies, as it facilitates developmentally orientated approaches and regulates growth and efficiency as a prerequisite for applying social justice through horizontal equity. To achieve these outcomes government structures had to move towards more flexible, faster and more responsive methods that advance community needs and had to become more customer-focused. PPP became an important part of the development strategies as it linked fiscal policy objectives to support growth, equity and price stability. The bottom-up approach to organisational planning promoted financial co-ordination which laid down measurable objectives and outputs. PPP integrated the operational budgeting process with the strategic intent and included actions that build human and financial resource commitments for strategic initiatives in their planning.

Initially the Reconstruction and Development Programme (1994) encouraged an upwards social mobility whereby state capacity was built through partnerships to meet the basic needs of society and develop human resources by building the economy and democratising the state and society through participation. The government avoided Structural Adjustment Programmes (SAP) prescribed by the IMF and World Bank and focused on Growth Employment and Redistribution (Gear) as this was premised on investment in becoming the driving force for growth by focussing on macroeconomic stability, curbing inflation and cutting the budget deficit. The Accelerated and Shared Growth Initiative for South Africa (AsgiSA) took over from Gear early in 2006. The emphasis in AsgiSA is placed on targeting the microeconomic reforms, focussing mainly on skills development and infrastructure development. At the core of the capacity-building initiatives lay BEE, articulated in the Strategy for Broad-based Black Economic Empowerment Act, 2003 which is interwoven in the Finance and Health Charters. Local

Economic Development (LED) strengthened the principle of community-based development while electoral processes aligned national and local initiatives.

International relations and partnerships are important drivers for economic growth and regional development. Case Study 5 is part of the Indian Ocean Rim (IOR-ARC) for Regional Co-operation, the southern African region in which COMESA, SACU and SADC are the principal organisations driving economic integration in the region and the EU and UN organisations (Breton-Wood agencies). Through its membership in the AU the government fosters continental unity and development in its support of ECOSOCC, NEPAD and APRM.

### **6.3.1.2 Economic factors**

Market outcomes and the role government plays in stimulating the economic environment are determined by the Constitution of the Republic of South Africa, 1996. A neo-liberal approach supports market-driven policies on trade, investment, employment and government spending. Growth and sustainability is achieved through increased investment in the National Health System (NHS) by strengthening the NHS through cost containment and the provision of equitable services. These outcomes are supported in the market-based strategies for PPPs that offered value for money, affordability and transferred risk to the private sector. During June 2003, the Growth and Development Summit Agreement strengthened the call for partnerships between government (public) and business (private) and civil society (NGOs). It became an integral part of the government's performance improvement strategy. The medium-term budget policy strategy (MTBPS) set out the government's major policy proposals and provides a framework for strategic intent. The strategy forms the basis for the national medium-term expenditure estimate (NMTEE) in that it supports the operational plans. The medium-term fiscal policy framework (MTFPF) focuses on realising the external opportunities and preventing threats through sound financial management of strategies and risks while the Medium Term Expenditure Framework (MTEF) forms the basis for a three-year budget cycle of spending on the national and provincial spheres of government. The PFMA, 1999 regulates financial management practices within the national and provincial spheres of government. Additional to the PFMA 1999, the intergovernmental relations between each sphere is spelled out in the Intergovernmental Fiscal Relations Act, 1997 which co-ordinates fiscal and budgetary matters. The Division of Revenue Act (DORA)

provides input and resources for the short-term activities set out in programmes and sub-programmes through the Appropriation Act approved in Parliament.

Case Study 5 is classified as a middle-income country, a dual economy with a sophisticated industrial economy that developed alongside an underdeveloped informal economy. The government's fiscal policy shifted its focus towards greater capital investment and skill intensity in order to provide more sustainable growth in medium- and short-term strategies. Unfortunately, the government faced fiscal exposure through increased HIV/Aids interventions and welfare support as it indirectly affected saving rates by increased spending shift that were created for health care, as well as increased demands made on social spending. No clear policy on Aids-related grants exists. Cost associated with care dependency grants increased and health expenditure grew towards 8.7% of GDP. HIV/Aids has moved from a health issue to a development issue with social, political and economic dimensions.

Poverty and Growth Programs (PGP) build on the capacity of middle income countries and implement effective poverty-reduction strategies. However, increased spending on health issues reduced spending on education which led to increased poverty levels as well as reduced skills accumulation changing the labour force growth rates. Through the implementation of PPP the opportunity was offered to introduce large investments from the private sector into the public sector and clear backlogs in infrastructure and service delivery. The socioeconomic arrangement and impact of HIV/Aids on employment showed a strong relationship among poverty, ill health and poverty-related illnesses. The impacts were more severe on the unemployed and unskilled labour category and the youth. The socioeconomic impact on the youth thus has serious negative effects for future economic growth and allocation policies.

### **6.3.1.3 Social factors**

The government took a developmental approach to social and health care reforms. Partnerships form the core of relationships and are an important aspect of creating a co-operative environment between public, private and NGO sectors. The Health Act, 2004 and Draft Health Charter support the White Paper for the Transformation of the Health System in South Africa (1997). All activities in the NHS are aligned with the Health Act, 2004 and the Public Service Regulations (2001) to form a comprehensive health care

program. However, mixed approaches are taken to HIV/Aids strategies. Interest groups still see HIV/Aids as a separate issue from health care with separate budgets and strategies. The national and provincial departments of health apply HIV/Aids as a separate entity of health with separate budgets which are not integrated in the NHCS. The MTBPS does see HIV/Aids as an integral part of development planning. PHC is seen as the main vehicle to deliver services regarding HIV/Aids and PPP becomes a mechanism to improve efficiency, customer service and revenue.

The growth of health markets and the growth in the private sector profits and shareholding impacted negatively on the net outcomes of the public sector. Increased inequities between public and private sectors developed. Resources moved towards private and expensive curative care with fewer resources available for PHC. Human resources moved from public to private sectors. PPPs were mainly interested in providing services where profits were to be made. Response to HIV/Aids was limited before 1994. Activity increased from 1999, and in 2000 a top-down approach in combination with vertical programmes was applied. HIV/Aids was placed on the national agenda and became part of the budget process. The Department of Health launched the HIV/Aids/STI Strategic Plan for South Africa, 2000-2005. The government initially approached HIV/Aids and TB as separate issues in health care through its “Enhanced response to HIV/Aids and TB in the Health Sector” (2001). More emphasis was placed on a co-ordinated response to deal with community home-based care, counselling and prevention through awareness campaigns in a National Integrated Plan (NIP) which served as an intersectoral government plan responding to HIV/Aids to be delivered jointly by health, education and DSD. Funding is organised in three streams:

- The first stream is nationally financed and implemented.
- Secondly, it occurs through conditional grants for provinces for specific interventions.
- Thirdly, provincial interventions are funded through the equitable share (DORA) and are intended to strengthen health care services.

Strengthening of partnerships with major sectors encouraged a bottom-up approach. Inequities of infrastructure and services in rural areas increased HIV/Aids-related problems and costs which forced the government to gradually shift its approach away from a system that is driven by national targets towards an integrated and intertwined

approach of HIV/Aids in the NHS. The introduction of the Health Act, 2004 and Draft Health Charter changed the previous approach to HIV/Aids strategies. The shift is supported in the MTBPS (2005) and the Health Act, 2004 in which the emphasis is on strengthening of the NHS through improved quality services, more emphasis on PHC, emphasis on outcomes-based approaches and demand-side factors in service delivery, the expanded role of PPPs and PPIs in health service improvement and increased investment in information technology.

#### **6.3.1.4 Technological factors**

Greater investment in information technology is crucial. Telemedicine and Information Technology Communities (ITC) brought a paradigm shift as health care is brought to the rural areas and the digital divide is reduced. Build-operate-transfer (BOT) scheme hospitals use well designed Information Technology (IT) Systems to manage patient data. The State Information and Technology Agency (SITA) developed an information system that is utilised in the NHS. Data management protocols are necessary to control the decentralised service delivery in health care.

#### **6.3.1.5 Legislative factors**

All programs in the NHS are based on “the right to health care” as determined by WHO regulations. International law influences policy decisions and legislation takes an integrationist approach as the right to health forms the core issue on which all decision-making is based and in which patients are central to the strategy in combating HIV/Aids. Informed consent and confidentiality providing dignity through antidiscriminatory treatment are the main objectives of treatment. Issues pertaining to HIV/Aids are dealt with through the Health Act, 2004. A regulatory framework for PPP procurement is provided through Regulation 16 of 2002 issued in terms of the PFMA (1999) which requires that all PPP projects in the national and provincial spheres must obtain approval from the National Treasury.

#### **6.3.1.6 HIV/Aids environmental factors**

Within the HIV/Aids environment, the Treatment Action Campaign (TAC) and pharmaceutical companies are powerful stakeholders. As interest groups they have become powerful lobbyists in policy agendas for HIV/Aids. However, conflict of interest between the private and public health sectors impacts on equities, cost structures and accessibility of services. The private sector strongly supports expensive curative care

(medical model) while public health sectors moved towards palliative care (social model) and support mechanisms that underline prevention in order that the government can provide affordable care to the masses. Sustainable development strategies are framed within the MDG, the Doha Development Agenda of the WTO, the Monterey Consensus on Finance Development and the World Summit on Sustainable Development (WSSD), 2002. The MDG sees poverty eradication as a major component in dealing with HIV/Aids issues. This is supported by NEPAD who recognises the interconnectedness between health and development. PPP becomes a mechanism in which capital investments by the private sector in infrastructure and human capital provide the opportunity to build state capacity which affects service delivery outcomes and as such becomes an instrument towards achieving sustainable development.

Overstretched budgets especially in health spending are unable to cope with the demands of societies in rural areas. Lack of adequate skills and inequalities in infrastructure in the public sector increased the pressures on government as 80 - 85% of its customers are unable to pay for services they receive. Added to this, South Africa draws heavily on migrant labour within its economy. The migrant labour system involves internal migration from mines and other places of employment. South Africa is one of six countries that form the global HIV/Aids epicentre in southern Africa. Swaziland, Botswana and Lesotho have the highest HIV/Aids. Labour is drawn from Botswana, Mozambique, Swaziland and Lesotho while the highest migration comes from Malawi, Zimbabwe, Mozambique and Lesotho. Against this background, the situation is exacerbated by a brain drain from developing countries to developed countries. Health care delivery is affected by medical staff moving from public to private sectors and from private to other developed countries (UK and US).

### **6.3.2 Internal task environment**

A situational analysis questioned the extent to which strategies have impacted on the task environment in Case Study 5 and set out to identify those factors that affected the roll-out plan for HIV/Aids policies. This was done by applying a theory of constraint (TOC), interviewing stakeholders (Annexure C), and testing the assumptions that frame preset ideas and notions. By applying a SWOT analysis gaps are identified within the system. The SWOT analysis frames the gaps that exist between outcomes in service delivery and strategic intent and determines its impact on the formation of partnership



agreements. The situational analysis took into consideration how the various policy implications were influenced by:

- The medium-term budget policy statement (MTBPS).
- The medium-term fiscal policy framework (MTFPF).
- The medium-term expenditure framework (MTEF) affected government's approach to service delivery and its strategic intent for health care.
- The Public Finance and Management Act (Act 1 of 1999), Division of Revenue Act (DORA) and the Intergovernmental Fiscal Relations Act, 1997 (Act 97 of 1997).
- Equitable share and conditional grants.

This meant that the researcher had to establish how the macro, sectoral and micro goals of fiscal policy shaped decision-making within the government's macroeconomic and microeconomic objectives and strategies towards strengthening the National Health Care System (NHCS). Secondly, the analysis scrutinised the Health Act 2004, in order to determine the main constraints that prevented the government from achieving the desired objectives in utilising its available resources as efficient, effective, economic and equitable as possible. Thirdly, as the study unfolded it became evident that conflicting ideologies between the health care sector and the National Treasury especially in the PPP environment, impacted on strategies and the type of interventions selected to strengthen the NHS.

#### **6.3.2.1 Health care reforms**

The health care reforms centred on strengthening and building a comprehensive NHS through improved quality in service delivery. PHC and DHC were utilised as the means by which provincial departments funded the implementation of health to improve the quality of service delivery. Health care reforms further supported effective government and management structures that led to increased human capital investment and empowerment (BEE) and by providing affordable and equitable services.

The MTBPS of 2005 did not separate HIV/Aids issues from the health care reform strategies but dealt with HIV/Aids as an integral part of the growth and development plans. The MTBPS proposes an "Operational Plan for Comprehensive HIV and Aids Care" implementing two key programmes in HIV/Aids. These key programmes are based



on a comprehensive Primary Health Care (PHC) plan and an Antiretroviral Treatment (ART) plan which encourages partnerships with pharmaceutical companies and partnerships with NGOs. The partnerships with NGOs mostly focus on education, home-based care and Voluntary Counselling and Testing (VCT). The funding mechanisms for these interventions are based in conditional grants and equitable share budgets for provinces. The departments of health and education continued their funding strategies under the conditional grant system while the department of social development falls under equitable share of the provincial budget (DORA).

Applying the PPP in the NHS became an important aspect of creating a co-operative environment between the public, private and NGO sectors in that it should benefit the health system as a whole as well as foster a developmental state that focuses on the strategic priorities providing for a comprehensive and holistic NHS. The high costs involved in PPP procurement for health infrastructure and its poor success rate due to an absence of high-level skills necessary to understand PPP as a procurement tool, created a resistance in utilising PPP as a procurement tool in the health care environments. This resistance grew stronger amidst arguments describing the PPP process as time-consuming and not always an effective mechanism for service delivery (Muller, 2005). The fragmented accounting systems in health, poorly constructed PSC tools and Department of Public Works (DPW's) traditional role in maintaining and providing health infrastructure complicated costing mechanisms. Questions in the health sector centred on how much value for money and efficiency was achieved through the utilisation of a PPP model (BOT scheme). During an interview, Muller (2005) pointed out that Inkosi Albert Luthuli hospital in KwaZuluNatal is an example of: "... a nice hospital but the jury is still out on exactly how much it cost us and could we have reduced or created a similar facility at less of a cost. The general consensus at the present moment is that the department could have done better."

The complexities associated with PPP in health care interventions for service delivery were increased by assumptions and asymmetric information. This made CBA ineffective tools due to asymmetric information provided by the medical profession and the array of assumptions that frame health care and the HIV/Aids environment. Fragmented accounting in the health care system increased complexities around transparency and weakened the functions of the state. Blurred boundaries between health, the Health Act

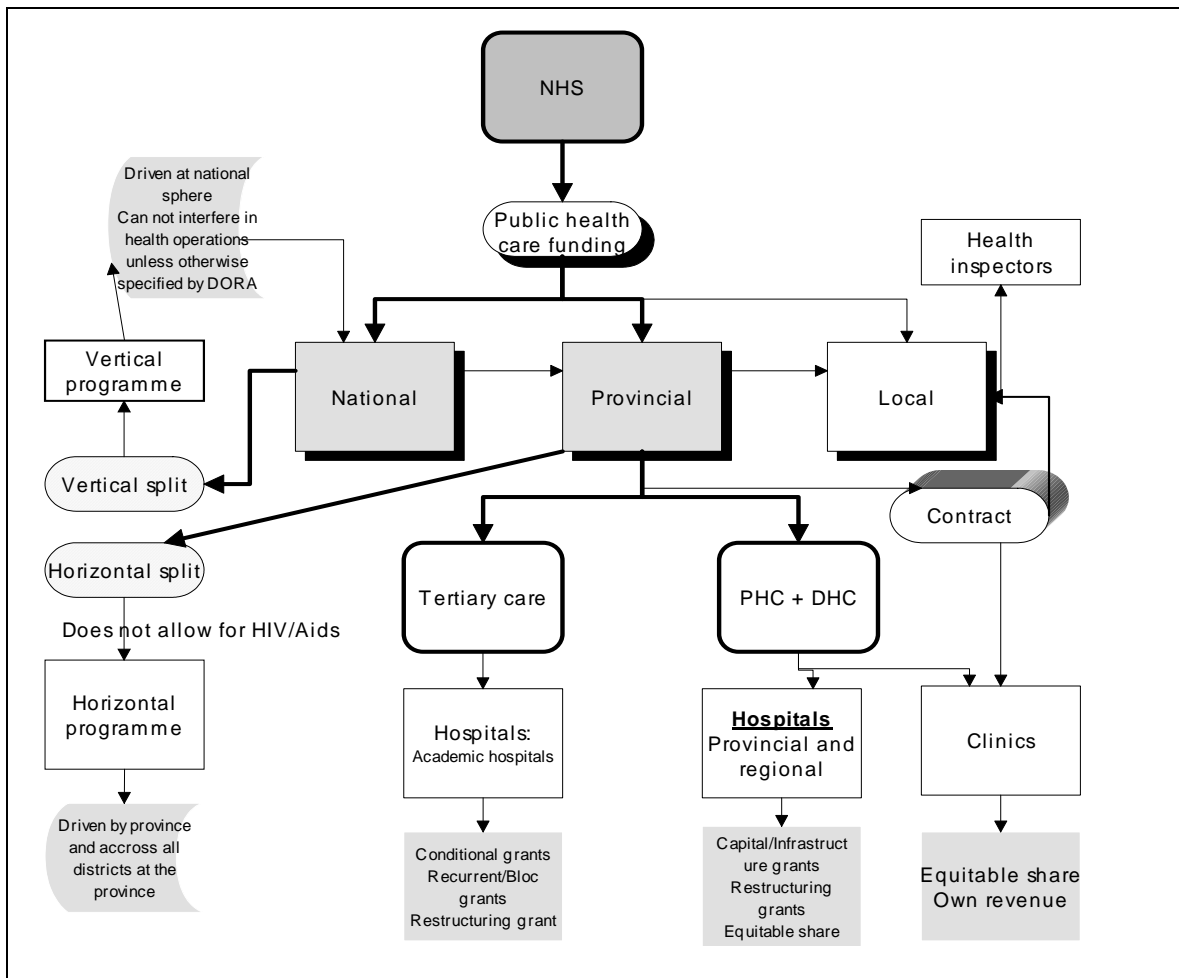
2004 and the PPP Unit (PFMA, 1999 and Treasury Regulation 16) strengthened the difference in focus and definition. The difference in focus placed an increased strain on intersectoral relations which are critical elements in the successful roll-out of PPP projects as this impacts on the successful alignment of strategic intent and operational strategies between the Department of Health and the National Treasury. Added to this scenario, blurred boundaries between PHC and DHC and PPP procurement and legislation complicated the identification of responsibilities and how accounting structures were designed to enhance effective service outcomes. The difference in strategic and operational focus between the Department of Health and the PPP Unit resulted in the development of PPIs that widened the gap between the PPP generic structure and the needs of health care and PPIs (Muller, 2005). The supply- and demand functions were perceived as ineffective as PPPs were unable to meet the needs of the health care sector as a whole in an effective and affordable manner through financing and provision of services and goods.

The Health Act, 2004 brought significant changes to future health care interventions. Devising output specifications, payment mechanisms and the monitoring of clinical services over and above everything that goes with maintenance operation of the health demanded new approaches and increased the complexities. Primary Health Care (PHC) provision is the responsibility of the provincial departments of health who must fund the implementation of all the health services. However, no consistent approach to service delivery exists between different provinces and different districts. The provincial department of health is responsible and accountable for ensuring that the district health system (DHS) works effectively (Muller, 2005). Clinics were shifted under the control of the Provinces (defined under the Health Act, 2004 and the Municipal Structures Act, 1998). Municipalities' categorised within Category A can still maintain clinics but must fund these from their own revenue basis. Provinces can also contract a local municipality to provide the services at a clinic, but at present there are no standardised rules or regulations (Muller, 2005). None of the municipalities' considered health care as their responsibility. With the implementation of the Health Act 2004, changes were introduced in the NHS which transformed the function and role of government in each sphere and impacted on financial structures. This influenced choices and the type of PPP or PPIs selected. The Health Act, 2004 redefines the role of the municipal health service (MHS) towards:

- Water quality monitoring, food control, waste management, health surveillance of premises, surveillance and prevention of communicable diseases.
- Restricting municipalities to the responsibility for the provision of environmental health services as opposed to a comprehensive PHCS.

The provincial government became the main implementer of the Health Act, 2004 which required the devolution of the environmental health functions that were currently rendered by provincial health departments to district and metropolitan municipalities (Ijumba & Barron, 2005:47). This change in definition impacted on funding mechanisms for CHBCS resulting in the phasing out of conditional grants within social development which moved towards equitable share mechanism of provinces (Ndlovu, 2005:1). While education and health sectors continued to receive conditional grant funds for HIV/Aids interventions, social development in provinces now allocated resources from the equitable share and own budgets.

Figure 6.1: NHS and funding mechanisms



Source: Own interpretation (2005).

Although significant problems were experienced since the conditional grants were introduced in 1998/1999, the Department of Health still prefers to utilise grants as its main source to finance projects in health care even though the Health Act, 2004 promotes partnerships as a means to strengthen the NHS. The conditional grants extend the effect of capacity-building and structural adjustments as well as clear backlogs and regional disparities in the economic and social infrastructure. The health sector made extensive use of the conditional grants to fund hospital revitalisation programmes as well as HIV/Aids programmes.

The Health Act, 2004 states that it aims to promote co-operation and shared responsibility amongst the public and private sectors within a context of national, provincial and district health plans (Ijumba & Barrow, 2005:47). Core instruments in this

process are the certificate of need (CoN) as it does not only achieve a more equal distribution of service delivery but also a more balanced approach to the skewed supply- and demand functions. This is seen as the most appropriate mechanism to reduce the wide disparity in health financing between the public and private sectors. Additionally, finding a balance between the relative size of the public and private health sectors within a mixed economy steered by its demand- and supply functions formed the pivotal point in accountability, responsiveness and finding fiscal responsible mechanisms in health care service delivery (Fourie & Schoeman, 2005:32). The task of securing and providing enough resources to cope with the demands made on health care is extremely difficult as health care is entangled in ideologies and personal values which are in synergy with social conditions and often depend in part on developments well outside the health sector. These emotional polemics are further tied to aspects of distributive justice and procedural justice and relates to each person's perception of distributive fairness or social justice.

The growing complexities surrounding relationships in service delivery moved the Department of Health to go beyond the relationships of financing and provision. The legislative framework for PPPs provides for a specific application and definition of the PPP model in the national, provincial and local sphere in South Africa. The South African generic PPP model prescribed by the PPP unit at the National Treasury was too rigid when applied in the health care sector mainly because the PPP model was not applicable in all circumstances and often did more harm than good.

Parallel to PPPs, in 2000, the Department of Health developed a policy document Public-Private Interactions (PPIs) which focused on creating improved relationships between the public-private sectors by improving its service delivery outcomes within the clinical field (Wadee, Gilson, Blaauw, Erasmus & Mills, 2004:14). PPIs formed an umbrella that pertained directly to various categories of actual health service and its method of delivery. In this scenario, PPP became one of the key categories within a variety of partnerships to be used in PPIs, namely:

- Purchased services.
- Outsourced non-clinical services.
- Joint ventures.
- Public finance initiatives (PFIs).

- Public-private partnerships (PPPs).
- Tax relief and asset swap (Wadee et al. 2004:24).

Different views of what constitutes a PPP developed. Pillay (2005) states: "... I want to have a point of clarification. PPP by its very nature cannot be a joint venture or outsourcing. The definition of a *PPP* is, we give a long-term concession to the private sector to provide infrastructure or services on behalf of government".

Although a massive input with regard to PPP occurred in the health care environment in general it was not utilised within the HIV/Aids environment (Pillay, 2005). Also, no PPP was found that dealt specifically with HIV/Aids except the pharmaceutical supply chain management (SCMC part of PEPFAR) contract which was awarded to the John Snow Inc. in November 2005. It was deduced from the interviews that the difference in service delivery outcomes between the public health sector and the private health care markets led to increased disparities between health care interventions. The government is working towards a social health care plan to reduce the effects of the disparities (Pillay, 2005). PPPs are advocated by the PPP unit as a means to make health care more affordable, while Department of Health sees PPP as a mechanism that increases the costs of health care adding to the burden of inflationary behaviour (Muller, 2005). The World Bank emphasises inefficiency, little autonomy and little discretionary funding to meet local health needs in the public health sector as contributing factors towards the disparities in service delivery (Picazo, 2005). They are concerned about utilising PPP as a means to increase the government's budget and in that way to try and improve services as this shifts the responsibility of solving problems to the private sector. The increased demands on goods and services have a big influence on costs in health care.

The private sector tends to be inflationary because it is supply-driven, prefers high-technology products and services and emphasises quality which means that it is supposed to be more efficient. Profits are the driving force in the private health care market which means that PPPs are only seen where profits are to be made (Muller, 2005). Providing health care in areas where high levels of poverty are experienced means that the public sector is the sole provider of health care and the focus shifts to demand-driven services. Mixed views on the efficiency and effectiveness of health care in the rural areas were given. It was perceived that in some communities the clinics are

more effective than in others (Pienaar, Venter & Maluleka, 2005). Accessibility of clinics therefore depends on community involvement. The main problems of accessibility were based on poor quality of services which included not operating at specified times (functional services) and overworked staff (technical services).

#### **6.3.2.2 PPP and value-creating strategies**

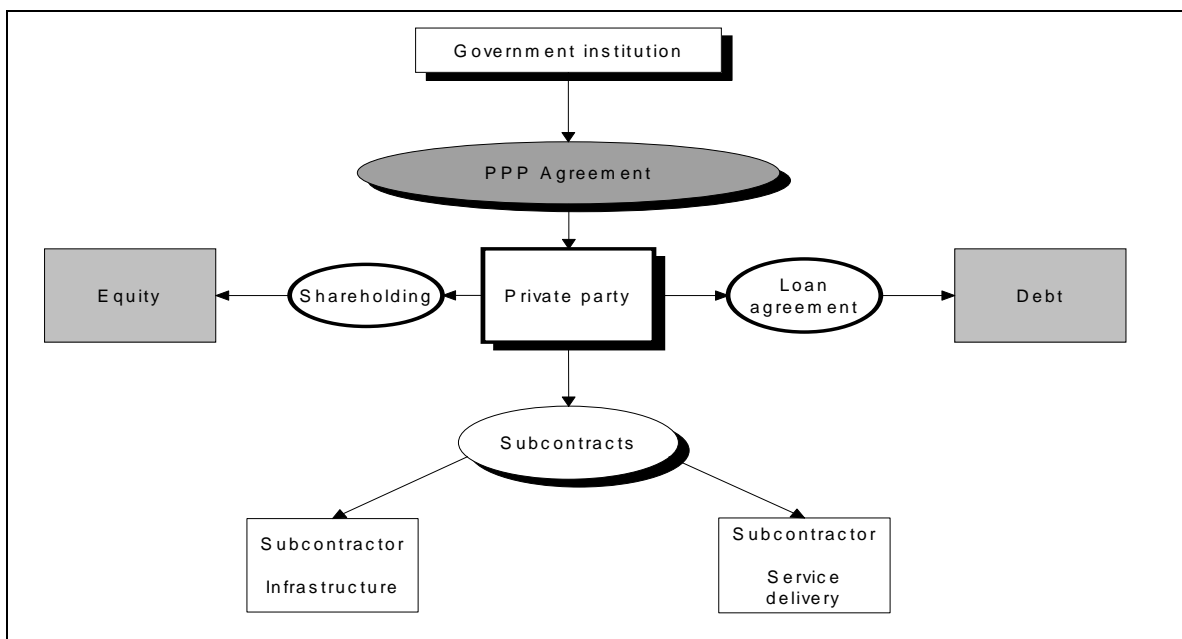
The National Treasury supported a value-for-money approach towards service delivery that offered affordability and risk transfer to the private sector to form the main criteria for decision-making. The PPP regulatory framework is based on the Constitution of the Republic of South Africa, 1996 (section 217 (1)). PPPs are supported by co-operative government and decentralised structures described in section 40(1) (2), and section 41 of the Constitution of the Republic of South Africa, 1996. The competitive and cost effective structures are provided for in the procurement, transparent and accountable structures, section 41(c) and supported in a development-orientated approach described in section 195 (c) of the Constitution of the Republic of South Africa, 1996.

The generic project finance model for a national PPP defined in Regulation 16 of the PFMA, 1999 as regulated by the PPP unit for national and provincial projects and therefore applied within the health environment is presented in Figure 6.2. Figure 6.2 is developed according to a BOT scheme and allows the government to build state capacity through long-term financial objectives which are linked to improved infrastructure delivery such as private sector investment, direct lending or balance sheet financing. The projects implemented in terms of the PPP model generally use project finance to fund the capital investments for health care initiatives. BOT schemes offer improved and affordable service delivery through operations and maintenance programmes, improve allocation policies through the mitigation of risk and provides opportunities for equity (BEE) and empowerment. PPP is used to leverage huge capital investments (project finance) from the private sector and optimise private sector involvement and efficiencies towards improved infrastructure and service delivery outcomes.

Worldwide, build-operate-transfer (BOT) schemes are the preferred option for utilising and strengthening health care services (Picazo, 2005; cf. Pillay, 2005). This model used private contractors to construct the building in which they are simultaneously responsible

for service delivery. By combining the risk of construction together with service delivery, meant that overconstruction of infrastructure was reduced and value for money would be achieved. Joining these two risks meant that the constructor will build and refine the building in such a way that it is sustainable and suits the needs of the population it serves (Picazo, 2005). Private sector investment prefers to invest where profits are to be made and are therefore not interested in becoming involved in BOT schemes or other forms of PPP that are unsustainable in poor and economic underdeveloped areas (Muller, 2005).

**Figure 6.2: Generic project finance structure for a national PPP**



Source: Adapted from PPP Unit (2004a:6); Treasury (2003).

According to the generic PPP model a *public-private partnership* is defined as “...a contract between the public sector (institution) and private sector (private party) where the private party performs an institutional function and/or uses state property in accordance with output specifications. Although substantial transfer of financial, technical and operational risks to the private party occurs, the private party benefits through unitary payments by the institution and/or user fees. The institution retains a major role as main purchaser of the services or as main enabler of the project” (PPP Unit, 2004b:4).



The PPP procurement focuses more on infrastructure development and financing. Efficiencies and management objectives in the private sector are guided by strong profit motives in order to achieve value-for-money outcomes in which the private sector manages its risks towards keeping a competitive advantage. PPP in health is about procurement of health infrastructure and clinical service delivery.

Feasibility studies support a strict procurement process underlined by the PFMA, 1999 and Treasury Regulations for the delivery of health services within the provincial sphere. The feasibility study and CBA are key areas for determining if a PPP offers best options at lower costs in health care. The feasibility study identifies risks thereby implementing effective management strategies and control mechanisms. The standardised PPP provision issued by the National Treasury as a PPP practice note in terms of section 76 (4)(g) of the PFMA is a template for the transfer of risk. Feasibility studies (CBA) are time-consuming as the process can take 40 months. It is imperative that all risks/constraints associated with the potential contract are identified and categorised. The impact of the risks on the overall performance of the project and how it contributes towards increased uncertainties and assumptions must be mitigated. An important part of assessing value for money is based on the public sector comparator (PSC) model as this tests the market. Service delivery is the driving force and main goal when a PPP is utilised. Evaluating the social costs and benefits as part of the feasibility study and CBA are central parts of government's social development strategy and requires that links with the expanded works programme and BEE are shown before continuing with the process. If the risks identified in feasibility study are not managed or transferred to the private sector it leads to poorly constructed agreements and a high risk of failure. CBA plays a key role in determining if value for money is achieved and identifies where social benefits are provided in the application of PPP. It therefore requires highly skilled personnel to implement and manage the whole PPP project cycle efficiently. Negotiations with unions are critical as their views impact on the success, timeliness and how relationships and co-ordination structures are implemented.

### **6.3.3 SWOT analysis**

Seven assumptions were identified in this study that framed problems within the field of HIV/Aids, health care reforms and PPP. Each of the assumptions directly influenced the perception of what the reality is. This meant that decision-making occurred in reaction to

the perceived problem. Testing and challenging each of the seven assumptions were necessary to seek out profound roots that prevented ongoing service and apply it as an effective tool in risk management. It was found that each assumption was perceived as a real truth within the HIV/Aids policy environment and this framed problem solving and decision-making around HIV/Aids, health care reforms and how PPP were implemented:

- HIV/Aids is seen as a medical and behavioural problem that can only be solved by medical treatments and by changing behavioural practices through abstinence, prevention and education. This view impacts on the type of interventions and strategies selected by policy-makers. Thoughts and decision-making on health care reforms, HIV/Aids and the utilisation of PPPs in health care are driven by medical professions and often tend to become one-sided.
- It is believed by some that antiretroviral drugs cure HIV/Aids and improves the quality of life and well-being of individuals. This approach sees HIV/Aids as a medical problem only and does not see it as an integral part of growth and development strategies.
- By improving health care services and strengthening systems and administrative structures, the responsiveness to HIV/Aids is improved. This is supported in the HIV/Aids/STI Strategic Plan for South Africa, 2000-2005 and the Strategic Priorities for the National Health System 2004-2009.
- PPP is a win-win situation in its application for the Department of Health in the case of multi-stakeholder interactions. The MTBPS encourages the utilisation of partnerships as a mechanism towards multistakeholder interaction and innovative funding mechanisms.
- Interactions between business partners (PPP) should be conducted as a “partnership” based on trust and mutual benefits. Agreements between business partners are constructed on trust and mutual benefits and tend to ignore the driving forces that shape the reasons for the business relationship.
- PPP as a policy paradigm in health care is the policy innovation of the new millennium. This argument forms the theoretical underpinnings for decision-making in the PFMA, 1999 but is contradicted by the actions and beliefs of the Department of Health.

In order to find the gaps between outcomes and the strategic intent, a SWOT analysis was conducted to determine:

- The external factors (macroeconomic) that identified opportunities and risks which influenced overall policy strategies proposed in the MTBPS, 2005 and MTFPF. This means the external factors identify those market success factors the government must implement in order to provide sustainable policy outcomes. It also identifies the requirements necessary to reduce risk taking (Republic of South Africa, 2005).
- The internal factors (microeconomic) and internal processes (strengths and weaknesses) that influenced approaches taken towards national funding mechanisms used in state intervention and health care reforms as prescribed in the National Health Act, 2004 and its subsequent impact on MTEF. The internal factors identify those distinctive competencies the government must implement in order to provide sustainable outcomes through its strategies and roll-out plans in service delivery.

An overview of the internal and external environments (Annexure H) identified those factors that influenced the government's ability to achieve its vision. Highlighting the internal strengths and weaknesses and identifying the external opportunities and threats in this analysis provided a clear identification of the strategic intent (market success factors plus risks) and the internal value-creation strategies (distinctive competencies) to be followed. Numerous environmental opportunities were available and strengthened government's competitive position within the global markets. Unfortunately, the findings presented in Annexure H weighed heavily towards critical internal weaknesses which had to be overcome if the the government wants to keep its position of power within the region and work towards gaining a competitive advantage within the international markets. This means that government supports a turnaround strategy which focuses on overcoming the internal weaknesses by building state capacity and strengthening existing structures. Building capacity and improved performance means the government can utilise the opportunities available to it and overcome some of the external threats. The importance and value of the application and impact of PPP in health care as a fiscal responsible mechanism are strengthened in the analysis as it becomes a core element in managing the whole public finance process towards achieving sustainability through value-creating strategies.

## **6.4 HIV/Aids interventions and strategies**

Value-creating strategies must be reflected in the long-term strategies (building the NHS), medium term strategies (increasing customer value), short-term strategies (operational excellence) that support the external (opportunities and threats) and internal factors (strengths and weaknesses) which have an impact on sustainable service delivery outcomes.

### **6.4.1 Criteria for best practices**

The ultimate objective in functional benchmarking involves the comparison between the international and national situation to identify the best practice and best value-for-money approaches in directing roll-out plans for HIV/Aids intervention strategies. By comparing the key issues between the international and national case studies, an attempt was made to isolate and identify where costs or outcomes are out of line. It determined the best practice and a particular activity according to experience, previous trends and perceptions that achieved sustainability and efficiency. It also proved useful in ascertaining whether the internal capabilities were strengths or weaknesses. This meant that a focus was placed on lowering costs to achieve value-for-money outcomes which were linked to excellence in performance and value creation in the long term.

#### **6.4.1.1 Effectiveness: goal attainment in service delivery (Case Study 5)**

Goal attainment in service excellence is measured against the achievement of “public good” (social justice and economic efficiency) and well-being within a framework of Constitutionalism and its definition of a social developmental state. Market forces set the tone for sustainable development. Public policy determines how the supply- and demand functions are put together (relative size of the public and private sectors) and how these sectors are intertwined with economic growth (allocation) and distribution of goods and services in health care. Public finance identifies the available revenues and determines efficient spending on public goods and services. It is the role of the government to manage intervention strategies in such a way that it complements and aligns policies between sectors and prevents monopolies from forming.

The improvement of quality of service delivery and cost reduction is ascertained when the PPP Unit performs its role as an enabler and regulator and provides facilitation and technical guidance in the achievement of goals. Transnational interaction is a

determining factor in policy and development initiatives and forms the core factor in the establishment of an effective state through the development of strong international relations and partnerships (UN, EU, NAFTA, APEC, ASEAN and AGOA) as well as an increased focus on forming regional relationships (SADC, SACU, COMESA, AU and NEPAD). Multinational and transnational corporations such as the pharmaceutical industry are powerful lobbyists and providers of goods. NGOs such as TAC, and INGO such as United States Agency for International Development (USAID), Oxfam and Global AIDS are important stakeholders in health services and strongly influence policy agendas of governments. UN organisations and EU play an important role in shaping policy decisions through international funding/aid.

The MDGs are interwoven in MTBPS, MTEF and DORA (budgeting process), Health Act 2004 and NEPAD. NEPAD identifies economic and political factors as most significant determinants of health. The economic and political factors determine who has control over the resources and who has decision-making powers. HIV/Aids is not separated from health but forms an integral part of health care and is therefore seen as a basic right rather than a commodity. PHC and DHC are instruments to meet community needs equitably in the bottom-up approach. The development thinking and utilisation of PPP are enforced through the strengthening of the NHS by means of infrastructure development and PPP (hospital and clinic revitalisation), human resource development, performance in contracting (PPI) and equity through procurement (BEE) as specified in the Draft Health Charter.

The PPP unit is an instrument that builds the government's policy capacity and implements effective and sustainable service delivery outcomes through procurement and partnership agreements. Forming vertical and horizontal networks between the state, society and the economy is a critical element in the successful execution of the agreements. More funding from the private sector (PPP) and minimal public finance for goods and services from the government resulted in a weakening of the state. Capacity-building and good governance structures support the government's drive towards effectiveness and efficiency in outcomes-based approaches. PPP is enforced in negative rights through justice (legislation) and is financed through private sector provision for public services in the form of loans, subsidies or grants and investments. PPPs are driven by a great deal of political influence with regard to desires and

outcomes. The electoral processes impact on political decision-making and funding decisions (raising and spending of public finance) within health care reforms. These processes determine citizen-state relationship and administrative systems and support structures, as well as the final decision on the type of PPP supported. Not sufficient emphasis is placed on outcomes-based approaches. This has a negative impact on growth and development as economic welfare results as it trickles down to all social groups. This happens because the social and health care systems do not operate in synergy with each other encouraging dependency which has negative impacts on health and well-being.

#### **6.4.1.2 Efficiency: outcomes in health care**

PPP modify market efficiency through forces of competition. It has a direct impact on productivity and employment which stabilises prices (inflation) and interest rates. Market competition is central to the process of procurement in PPP as this encompasses a framework of market accountability. Market accountability becomes the core issue in PPP design.

Competitive procurement processes are the preferred option in providing health services and goods. Competitive procurement encourages allocative efficiency and fiscal responsibility through the utilisation of PPPs. The distribution of resources is interwoven in the budgeting processes leading to better value-for-money approaches and allowing for the balancing of competitive tensions with cost-reductions as result. This is necessary to achieve programme effectiveness linked to feasibility studies and conditions specified in the bidding process. In this way, efficiency and increases on returns (ROI, NPV) will be determined. The effects of individual actions on the outcomes are determined through risk allocation, namely balancing technical, operational and financial risks. Strategic issues are based on substantial transfer of risk to the private sector which provides a large net gain for the public sector. The management and reduction of monopolies impact on revenue structures. Health services are a combination of rival (particular, quasi-collective and private) and non-rival (pure and impure public) services and goods. Decentralised fiscal structures support a framework in which local decision-making supports tax cost and finance structures. PPPs are developed in terms of local rather than centralised decisions, however, these decisions are regulated through the PPP unit (centralised agency). In procurement legislation, the emphasis is on the upgrading of

infrastructure through PPP because inadequate and run-down physical estate hampers the delivery of clinical services (PHC). PPP foster national prosperity through investment in physical and human capital (long- and short-term objectives) thereby encouraging the achievement of social goals (benefits). The importance accorded to private income enhances the negative effects of economic poverty. Value-for-money outcomes are provided in quality through PPP in its intrinsic value through social good (PPP impacts on accessibility, security and empowerment) and extrinsic value (PPP structures support a framework that draws on technical quality and human resources).

Performance standards and cost-benefit approaches are tied to performance agreements that specify an efficient supply of inputs and efficient spending mechanisms achieved through satisfactory negotiations between all stakeholders. New standards of accountability are directly tied to performance standards and a cost-benefit approach. These decisions are influenced by a shift towards horizontal and broader-based policy issues (HIV/Aids strategies) and show no respect for boundaries or do not fit neatly into areas of jurisdiction resulting in sectoral blurring.

#### **6.4.1.3 Economy: cost containment and the strengthening of service delivery**

Utilising PPP to contain costs and strengthen service delivery in all spheres of government moves government intervention strategies into an enabling, facilitating and regulatory role. The government as an enabler pursues equality of opportunity through modified markets within a mixed economy. PPP becomes a fiscal planning tool at macro level and forms an important part of the budgeting process. On the strategic and technical level, the decisions on who delivers the services is based on the directive of the ministry set out in strategy (MTBPS) while on the operational level, transfer payments must be budgeted for every year through DORA and over a three-year period through the MTEF. The government assists the private sector/economy to provide goods and services through subsidies or loan agreements and provides infrastructure through its own capital. Government option (DPW) is very complex when applied to the health sector. Huge capital investments are made over long periods by the private sector through concessions (15-25 years) in infrastructure. The BOT schemes are the preferred option in health and hospital revitalisation projects because it combines construction and service delivery and prevents overconstruction and underutilisation. Through the BOT schemes the government is able to transfer risk to the private sector and negotiate costs

with the contractor in such a way that it satisfies both stakeholders and provide sustainable flow of fiscal resources. The PPP unit is developing thresholds on when PPP is a viable option to pursue (Pillay, 2005).

The government as a facilitator and co-ordinator has to manage and manipulate internal markets with the production of social goods by contracting out public services to suppliers in health care through PPP and PPI. Benchmarks (PSC) form the basis of the feasibility study as it demonstrates affordability and value for money in risk-adjusted costing and provides estimations for particular interventions. However, the Standardised Public-Private Partnership Provision issued by the National Treasury is perceived as being too rigid and complicated and therefore prevents innovative approaches to be utilised through the construction of PPP in health. The importance of parallel monitoring and evaluation mechanisms increased as more and more PPP/PPI arrangements are put together. The PPP unit forms the intermediate in negotiations between government departments, private sector and NGOs. It plays an important co-ordinating role with unions and other stakeholders during the negotiation phase. BEE is applied in PPP and in line with the broader BEE policy. The BEE policy is also integrated in the Health and Finance Charters (Draft Document). No legislation is in place to deal with public sector transfers and benefits to the private sector, but if employees do not sustain or improve their work conditions the PPP unit prevents the deal from going through (Feasibility and CBA indicate social benefits).

Partnerships moved the government into a regulatory role where the PPP unit is the overseeing agency which provides technical support and guidance and enforces specific operational standards as set out in regulations and legislation. The PFMA determines the procurement and budgeting processes and presents guidelines for accountability structures. The PPP unit negotiates the basis upon which services are regulated and bound up in terms of agreements/contracts. Economic and social regulations force actors to undertake certain activities that benefit society. The PPP process enables value choices through the generic project life cycle that forms the basis for service delivery.



#### **6.4.1.4 Equity: social justice**

Market-based approaches within a mixed economy shifted the government towards outcomes-based expenditure measurable in value-for-money approaches which are tied to horizontal and vertical equity in the budgeting process. The optimal balance in the socially acceptable distribution of income is applied through redistribution of wealth (equity-based). This is achieved through wealth-creating initiatives where PPP demands a link with the expanded works programme (DPW), utilising employment programmes, subsidising low-paid jobs or retraining schemes and highlighting the social benefits in projects. Empowerment through BEE is integral to PPP negotiations. Political decisions and electoral processes affect policies on redistribution and the achievement of optimal taxation. Social justice provides the framework for tax policy.

#### **6.4.1.5 Implications of the 4Es Framework for the public sector and public finance (Case study 5)**

The social model regulates health care decisions and forms the central point in development, equity and empowerment. Partnerships allow for increased access to health care through affordability and efficiency. This is achieved by bringing in socialised health care provision in the public sector to balance out the effects of the private health insurance on the relative size of the public and private sectors. The introduction of the Government Employers Medical Scheme (GEMS) aims to reduce the effects of inflationary costs in health care and make health care accessible to the poor. The private sector expenditure has grown faster than public expenditure due to high inflationary costs leading to an increase in a skewed and growing divide between the public and private health care sectors. Equity in the distribution of health systems became a core determinant in establishing effective strategies. Increased demands in social development and health care placed a heavy constraint on the state finances. PPP offers mechanisms for the strengthening of social development. Allocative and distributional policies within a framework of social justice and economic efficiency are a core issue in policy-making and strategies for health care. HIV/Aids interventions placed heavy constraints on the public finance in realising the government's role as an enabling state and thereby strengthening the NHS. PPP offers additionality through private investment and partnership agreements (BOT schemes are the main vehicles used by PPP unit and on which legislation is built). A dedicated tax for HIV/Aids is proposed in a study conducted by the Nelson Mandela Trust (2005:144) as costs of providing ARV are expected to escalate. This is proposed as a recommended option to ensure the

sustainability of ARV therapy programmes. However, implementing a dedicated tax for HIV/Aids is not a simple solution for a complex problem. Adding to the tax burden without careful consideration of its social impact can often have the opposite effect on economic growth and well-being. Increasing fiscal pressures through added tax structures may increase the burden on those whom government aims to assist and also come to increase the costs of social security for government. Utilising the PPP model within the HIV/Aids environment demands a comprehensive knowledge how the model can be best applied as part of the expansionary budget approach and in ensuring productive public expenditures.

The PPP model relies on how it manages borrowing debt for efficiency purposes through loans from the private sector. Currently, the country has a 1% borrowing/GDP ratio which reflects that the government's overspending is very low for a developing country. External influences and risks impact on the management of interest rates and therefore indicate that the internal processes are controlled. Mixing public-private finance by encouraging additional private sector expenditure through highly productive public sector investments in both human and capital investments supported through Black Economic Empowerment (BEE), ensures productive expenditure. Equity investors (BEE) are integral to the procurement process. However, due to tax obstacles based within equity and shareholding it has discouraged more widespread share ownership of employees. The government must align BEE initiatives with tax legislation, particularly if disposal of assets are required to settle part of loan obligations. One therefore has to try and achieve greater unconditional redistribution of income through tax and social security systems by ensuring that the public expenditure is as economically productive as possible.

#### **6.4.2 A search for alternative strategies and policies**

In a search for alternative strategies and policies that allowed the government to overcome its own weaknesses, two instruments explore the strategic architecture of efficiency and effectiveness themes as well as mirror productivity and revenue growth. On the one hand, value-creating strategies were linked with a series of cause-and-effect outcomes while on the other hand a social cost-benefit analysis provided insight into particular allocations of scarce resources and how investments provided opportunities to

be shared amongst the public, private and NGO sectors as well as identified opportunities between consumers and producers.

Value creation and strategic intent became key issues that minimised and overcame the negative threat that HIV/Aids-related problems posed for the NHS and public finance structures. Although the frameworks utilised for value creation in the public, private and NGO sectors are similar, there are several important distinctions that influence value creating actions in the PPP environment (investment) and these should be highlighted as follows:

- The ultimate definition for success in public and NGO sectors is based in their mission statement (Kaplan & Norton, 2004:7). However, the public sector and NGOs span a broad and diverse set of missions to define their social impact and high-level objectives. Value creation and strategic intent are based on meeting the needs of targeted customers. Success is created through internal process performance and reflects the objectives of the electorates, taxpayers or donors who supply funding. Furthermore, success is supported by the intangible assets of the human capital through learning and growth (Kaplan & Norton, 2004:9, 199).
- This is different to the private sector that uses homogeneous financial perspectives based on the increase of shareholder value, and for which all actions are guided by profit motifs.

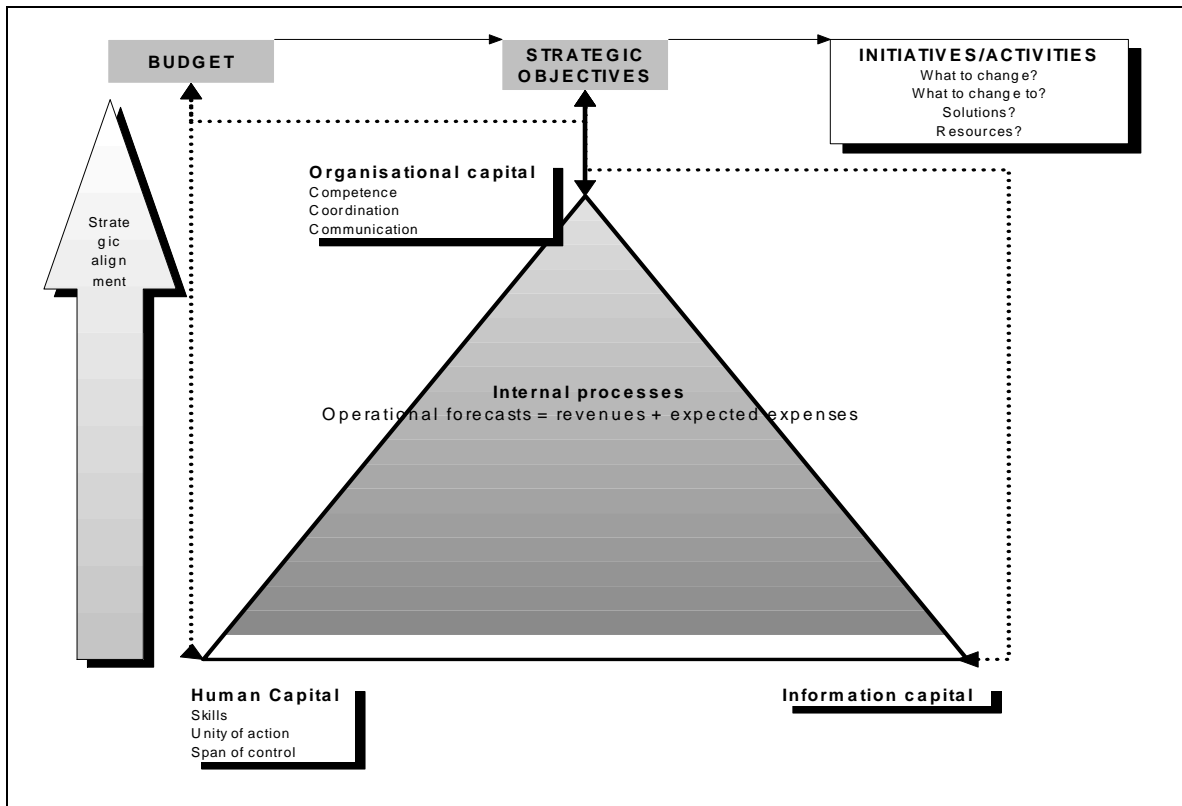
One can therefore conclude that a value-creating strategy provides strategic measures not as performance indicators but as a series of cause-and-effect linkages amongst objectives. These linkages identify specific capabilities that promote exceptional performance in the internal environment. The extent to which strategies impacted on the roll-out plans for HIV/Aids policies were mainly influenced by the components and interrelationships that existed between internal process measures and customer value propositions in health. Added to this, problems were exacerbated by issues such as no clear objectives for innovation (rigid organisational structures based on strict vertical authoritative structures) set within strict regulatory control mechanisms, vague objectives for employee skills and motivation (absence of effective performance evaluations and job matching) as well as an absence in determining the role of information technology as a value-creating mechanism (Kaplan & Norton, 2004:13). However, human resource and

IT investment per se are unlikely to facilitate the organisation's ability to execute their strategies or generate a positive return on their human resource or IT investment. Kaplan and Norton (2004:10) identify several principles which form the theoretical underpinnings for value creation proposed in this study:

- Strategy balances the short-term financial objectives for cost reduction and productivity improvements tied to long-term objectives of possible revenue growth.
- Strategy is based on differentiated customer value propositions and their WTP. Clarifying the value proposition and defining the attributes that must be delivered to satisfy the customer are important dimensions.
- Sustained value-creation is achieved through strategic themes.

How these principles are combined and applied to health care policies lead to the success of the value creation and improvement of service delivery outcomes. Identifying core aspects that influence performance and then aligning the constraints with the internal processes offer the opportunity to provide practical solutions for the actions that supports a 4Es framework in roll-out plans for HIV/Aids intervention. Each of the linkages (human capital, information capital and organisational capital) provides strategic measures necessary to achieve change towards value-creation and identifies those issues and capabilities that are critical in achieving improved quality and efficiency in service delivery in health care. Figure 6.3 demonstrates the strategic alignment of the organisational, human and information capital with the internal processes that have a critical impact on the outcomes of strategy. Critical elements within the organisational capital such as leadership, organisational culture and teamwork must be combined with horizontal and vertical hierarchies and the administrative structures that support health outcomes.

Figure 6.3: Strategic measures to achieve value-creation in HIV/Aids strategies



Source: Own interpretation (2006).

One can therefore deduce from Figure 6.3 that service delivery within the HIV/Aids environment depends on how the organisational, human and information capital is aligned with the overall strategic priorities within the budgeting processes. The sharing of synergies across sectors through balanced supply- and demand programmes strengthens efficiency and the achievement of strategic goals. The alignment of financial implications such as:

- Direct costs on health expenditure.
- The indirect costs on the economy.
- Intangible cost impacting on how the community reacts to the problem (image), must be taken into consideration with the Batho Pele principles and in determining strategic choices.

These choices are influenced by the impact that HIV/Aids has on the overall health care system. Each of the phases of HIV infection requires specific sets of medical, administrative and managerial interventions. Table 6.2 identifies in terms of a

comparison of the cost-benefit analysis of the with-and-without approach the benefits or positive costs for HIV/Aids and the negative costs resulting from HIV/Aids.

**Table 6.2: Cost-benefit analysis applied to health care and HIV/Aids**

<b>With: Benefits or positive costs</b>	<b>CBA: Health care and HIV/Aids</b>	<b>Without: Negative costs</b>
Savings in expenditures.	Direct costs (health expenditure).	Expensive long-term treatments and long periods of hospitalisation. Chronic relapses. Travelling, inaccessibility of health care. Increased poverty due to poor health.
Restored earnings. Restored revenue and tax base.	Indirect costs (forgone earnings) = inputs and outputs that pass outside the health care.  The main measure of indirect effects is via earnings forgone or enhanced due to treatment, impacting negatively on productivity, education and social issues.  Determines quality of care and the willingness-to-pay (WTP) which is measured by market price.	Sick leave, absence for long periods, unemployment, loss of income.
Reduction of pain and suffering.	Intangible costs (pain, suffering associated with treatment or intervention)	Stigma. Mental health depression. Side-effects of medication. Building resistance to medication.
Outputs or effects = quality-adjusted life-year (QALY)	Consumer surplus	Inputs or costs

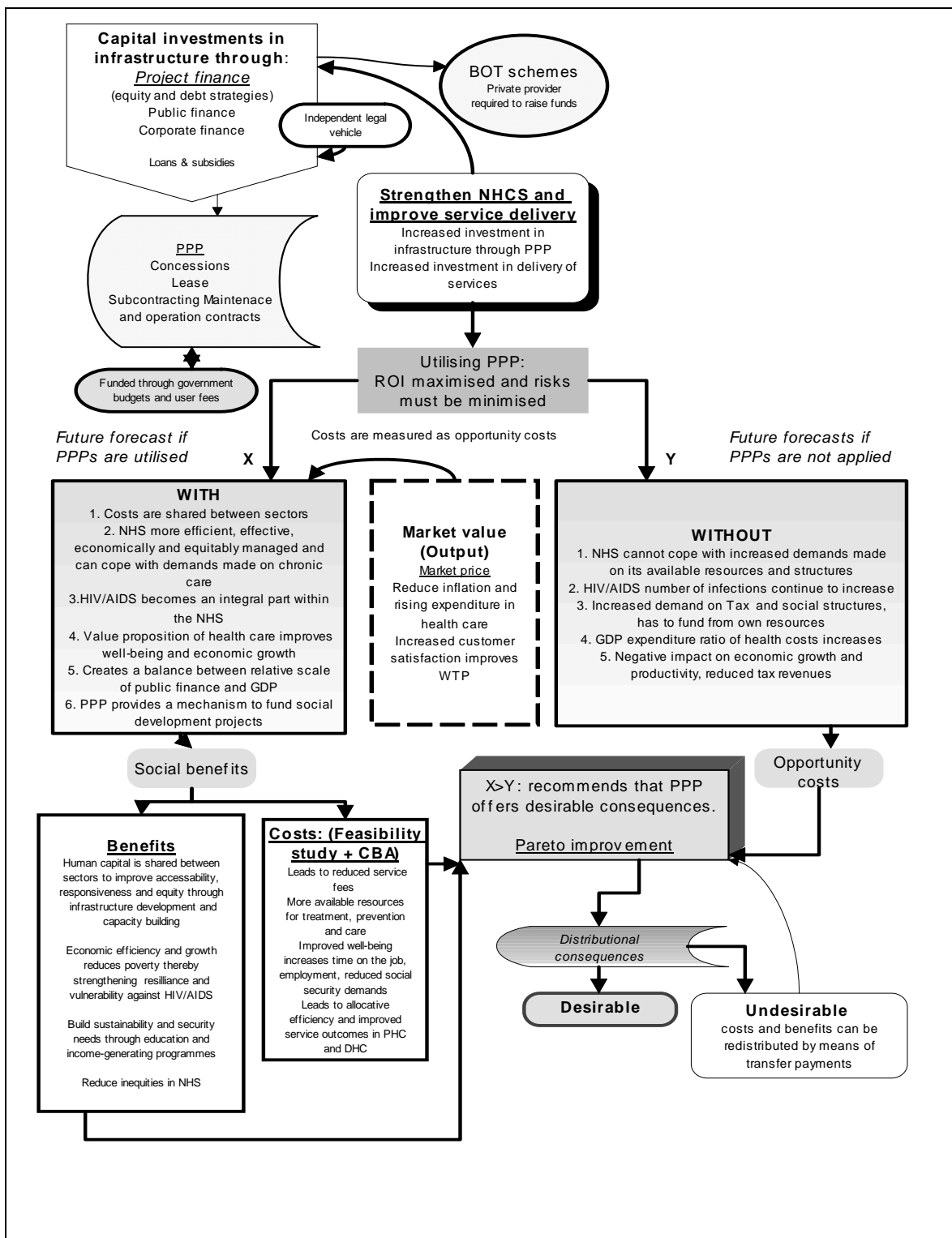
Source: Adapted from Brent (2003:5); Campbell and Brown (2003:2,3).

Integrating the three types of costs that influence health care in the design of efficient supply and demand functions (direct costs, indirect costs and the intangible cost) identified in Table 6.2 clearly shows that the negative costs of HIV/Aids interventions have a direct impact on profits, NPV and ROI and the interest of shareholders. When PPPs are established these factors become a determining point in the approaches taken to HIV/Aids in health care interventions. The NPV and ROI also determines if PPP is a viable option. Strengthening the health system and building capacity can only be achieved if HIV/Aids interventions become an integral part of the overall health strategies (applied within a NHS) and must not be seen as a separate entity in the attainment of goals in health care and service delivery.

A social cost-benefit analysis determined the effect of improving efficiency of public sector investment through the utilisation of PPP in health care, as well as its direct impact on the future value of roll-out plans for HIV/Aids intervention. Good investment provides value for money benefits to the economy as a whole. Utilising PPP as a mechanism that provides good investment has a carry-through effect on all sectors of health care. The with-and-without approach used in Figure 6.4 forms the pivotal point for the cost-benefit approach and measures the difference investments made in providing health care and social development opportunities. Likewise, the concept of opportunity costs underlines the value of services and goods. The benefit is based on the increased value of future supply (NPV).

The generic PPP model defined within the PFMA does not include PPI within its framework. The rigidity of the PPP model, absence of skills in the Department of Health to manage PPP relationships and the complexities surrounding the model when it is applied to health interventions, prevented the health sector from utilising PPPs as an effective mechanism. A strong resistance against the PPP model meant that alternative models were developed in competition to PPP, instead of identifying the social costs and benefits the model offers in health care and mitigating the risk factors that turned the PPP model into an unfriendly and complex model.

Figure 6.4: Social cost-benefit analyses for PPP applied in NHS: Case Study 5



Source: Adapted from Campbell and Brown (2003:3-5); Brent (1998:5).



Figure 6.4 showed that PPPs offer desirable consequences for Case Study 5. In establishing the type of social costs and benefits that are created through the application of PPP, it is recommended that the PPP model should take a broader focus. PPP intervention is a value-creating instrument as it forms an important part of procurement and becomes a macro and microeconomic development tool if it is used with skill.

## **6.5 Conclusion**

Chapter 6 provided an in-depth discussion of the key issues and key performance indicators that underscored HIV/Aids strategies within the international and national environment. It measured outcomes against benchmarks that explored the influence of ideologies on the approaches that each country took to improve well-being and the public good. Business and management instruments supported by interviews and a literature review framed the core problems associated with policy-making in health care, HIV/Aids and the PPP environment. The outcomes of the systematic exploration presented best practices in building capacity and strengthening policy capacity within the government. Exploring the value of PPP as a mechanism to improve efficiency in service delivery within a framework of 4Es applied to health care and HIV/Aids became a core issue in addressing the research question.

The next chapter compares the results of the case studies and highlights issues, trends and options derived from each analysis as these outcomes are steered by the NPM movements in developing fiscal reforms that increased state capacity. The fiscal reforms reduced costs in health care spending, thereby establishing the extent to which strategies have impacted on the roll-out plans for HIV/Aids policies in South Africa.